

CERTIFICATE OF DEATH

03722

03716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner not used and released

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Naama Allen</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Allen</u>		14. MOTHER'S MAIDEN NAME <u>Edna Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Edward L. Allen</u>		Address <u>3930 -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>8 mo.</u>	
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Essential Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>Mar 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 1967</u> , and that death occurred at <u>4:01 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Herbert Bauerfeld</u>		22b. DATE SIGNED <u>3/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Herbert Bauerfeld</u>		22d. ADDRESS <u>2401 Calvert St. NW - DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-8-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W., Wash. D.C.		DATE <u>MAR 9 1967</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03723

CERTIFICATE OF DEATH

03717

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>HAYIE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mocksville</u>	
c. LENGTH OF STAY IN 1b <u>18 days</u>		70-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>843 N. Main St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Jennie Anderson Anderson</u>		4. DATE OF DEATH <u>MARCH 25, 1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-31-75</u>	
9. AGE (In years lost birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Blackwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>243-74-5377</u>	
17. INFORMANT <u>Washington Sanitarium records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 5400 DUE TO (b) <u>Vagus GI Bleeding</u> DUE TO (c) <u>Gastric ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>4.6 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-8</u> , 19 <u>67</u> , to <u>3-25</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>3-25</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. H. Sandstrom</u>		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u>		22d. ADDRESS <u>7701 Carroll Ave, Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/29/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Cemetery</u>		23d. LOCATION (City, or Town) (County) (State) <u>Mocksville, Davie Co., North Carolina</u>	
24. FUNERAL DIRECTOR <u>Richard Walters</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>254 Carroll Street, N.W., Washington, D.C. 20002</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 27 1967</u>			

03110

CERTIFICATE OF DEATH

03110

State of New York
County of [illegible]

I, [illegible], of the County of [illegible], State of New York, do hereby certify that

[illegible] was born on [illegible] day of [illegible] 19[illegible]

at [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and died on [illegible] day of [illegible] 19[illegible]

at [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

and the death was caused by [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

03724

CERTIFICATE OF DEATH

03718

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>1018 8th St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>OTHELLO</u> Middle <u>C.</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/31/10</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Ass't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Clark Cty. Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT H. ANDERSON SR.</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE THURMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>258-05-6223</u>	
17. INFORMANT <u>JANICE ANDERSON DODGGS - RICHMOND, VA.</u>		Address <u>2030 REYMET RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>E. Coli Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Lymphatic Leukemia</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 65</u> , 19 <u> </u> , to <u>3/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>67</u> , and that death occurred at <u>11:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Reed</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem.</u>		23d. LOCATION (City or town) (County) (State) <u>Sutland Md.</u>	
24. FUNERAL DIRECTOR <u>E.T. Murray mpr</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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MAY 23 1961

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				d. STREET ADDRESS <u>8003 Eastern Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Arhontis</u> Middle <u>Angelo</u> Last <u>Angelo</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-6-92</u>		9. AGE (In years lost birthday) yrs. <u>74</u>	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>415-16-1538A</u>		17. INFORMANT <u>JIMMY ANGELO</u> Address <u>12006 BLUE HILL RD. S.S. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal varices</u> DUE TO (b) <u>portal cirrhosis</u> (c) <u>Heart Hepatic failure</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>3/4</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>67</u> , to <u>3/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> , 19 <u>67</u> , and that death occurred at <u>5:30 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William Falk Marcus</u> M.D.				22b. DATE SIGNED <u>3/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>William Falk Marcus</u>	
22d. ADDRESS <u>Holy Cross Hosp. S.S. MD.</u>				22e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7 MAR. 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC.</u>	
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME WASH. D.C.</u>				25a. REGD BY REGISTRAR <u>MAR 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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UNITED STATES OF AMERICA

NAME		LAST		FIRST		MIDDLE		SUFFIX	
DATE OF BIRTH		MONTH		DAY		YEAR		PLACE	
SEX		MALE		FEMALE		OTHER		UNKNOWN	
RACE		WHITE		BLACK		HISPANIC		OTHER	
EDUCATION		HIGH SCHOOL		COLLEGE		POSTGRADUATE		OTHER	
OCCUPATION		FARMER		LABORER		PROFESSIONAL		OTHER	
MARRIAGE		MARRIED		SINGLE		DIVORCED		WIDOWED	
RELIGION		CATHOLIC		PROTESTANT		JEW		OTHER	
POLITICAL PARTY		DEMOCRAT		REPUBLICAN		OTHER		UNKNOWN	
CITIZENSHIP		NATURALIZED		BORN IN U.S.		OTHER		UNKNOWN	
MILITARY SERVICE		ARMY		NAVY		AIR FORCE		OTHER	
RECORDS		1940		1950		1960		1970	
REMARKS		1940		1950		1960		1970	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G387-1-17/67

CERTIFICATE OF DEATH

03726

03720

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb 26 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DONNIE Middle DEVADA Last ARMS		4. DATE OF DEATH Month 3 Day 29 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-03/04
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BOYD JACKSON		14. MOTHER'S MAIDEN NAME MARGARET LOWE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MEDICAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Sept 1966 to 3/29 1967 that (H) (we) last saw the deceased alive on 3/29 1967 and that death occurred at 3:25 PM from causes and on the date stated above.			
22a. SIGNATURE A. F. Woodward		22b. DATE SIGNED 3/30/67	
22c. PHYSICIAN'S NAME (Type) A. F. WOODWARD, M. D.		22d. ADDRESS 115 N. VAN BUREN ST., ROCKVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-1-67	
23c. NAME OF CEMETERY OR CREMATORY Crest Lawn		23d. LOCATION (City or Town) (County) (State) Alpha Heights, Md.	
24. FUNERAL DIRECTOR Arthur H. Hight		25a. REC'D BY REGISTRAR DATE APR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

1944

1944

STATEMENT OF DEED

RECEIVED

RECEIVED

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15 DAYS

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HICKORY HILL LABORATORY

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27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03727

CERTIFICATE OF DEATH

03721

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT OF Columbia</u> 47-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u>				d. STREET ADDRESS <u>4201 MASS. AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SHIRLEY S ASHTON</u> First Middle Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-80</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Civil Service U.S. Govt</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (County & State, or foreign country) <u>KING GEO. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Charles Henry ASHTON</u>				14. MOTHER'S MAIDEN NAME <u>Ida B. Welch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>— —</u>		17. INFORMANT <u>Betty P. ASHTON, - See Item No. 2</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atrial Fibrillation; Periodic Complete Heart Block</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 20, 1966</u> , to <u>March 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1967</u> , and that death occurred at <u>11:24 A.M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>C.R. Gruver</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. C.R. Gruver</u>				22d. ADDRESS <u>915 19th St NW Wash. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>3-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Episcopal</u>		23d. LOCATION (City or Town) (County) (State) <u>King George, Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W., Wash. DC</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

157281

EXHIBIT OF DEATH

157281



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03728

03722

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darnestown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darnestown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12916 Scarlet Oak Drive		d. STREET ADDRESS 12916 Scarlet Oak Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Steven Middle M. Last Bailey		4. DATE OF DEATH Month March Day 1, Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1956	9. AGE (In years last birthday) 10 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter M. Bailey		14. MOTHER'S MAIDEN NAME Phyllis Ann Coulter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Walter M. Bailey - father - item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia -</u> 9029 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>Compression of chest.</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 10 min?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell in deep hole in ground squeezing chest.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3:15</u> p.m. <u>3/11</u> 19 <u>65</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hole in ground -</u>	
20f. (City or town) <u>Darnestown Mont.</u>		20g. (County) <u>md</u>		20h. (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John H. Ball</u>		M.D.		22. DATE SIGNED <u>3/2/67</u>	
EXAMINER'S NAME (Type) <u>John H. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF <u>3/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY Darnestown	
23d. LOCATION (City, town or county) Darnestown, Maryland		23e. LOCATION (City, town or county) Darnestown, Maryland		23f. LOCATION (City, town or county) Darnestown, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS 1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR MAR 6 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0375

0375

Asphyxia -
Compression of chest.

Full report this afternoon regarding chest.

3/11/12
X Hb in spec. Donations sent 1/14
X X

X

John D. Ball

X 3/12/12

MAY 1963

12
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03723

CERTIFICATE OF DEATH

03723

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>20 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>1520 Chillum Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Seaboard</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ETHEL M. BARDOUCHE</i>		4. DATE OF DEATH Month Day Year <i>March 29 19 67</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-26-16</i>
9. AGE (In years last birthday) <i>50</i> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mary Sup't. Stenographer</i>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Joseph P. Bardouche</i>		14. MOTHER'S MAIDEN NAME <i>Mary Collins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>399-07-1299</i>	
17. INFORMANT Address <i>Forta Prince</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toxemia</i> DUE TO (b) <i>metastatic carcinoma colon</i> DUE TO (c) <i>surgical resection obstructed Ca colon</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>		20. MEDICAL CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-4-67</i> , 19 <i>67</i> , to <i>3-29-67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-29</i> , 19 <i>67</i> , and that death occurred at <i>5:30 P</i> M, from causes on and on the date stated above.			
22a. SIGNATURE <i>John O. Robben</i>		22b. DATE SIGNED <i>3-29-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>John O. Robben MD</i>		22d. ADDRESS <i>10400 CONNETTICUT AVE KENSINGTON MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE THEREOF <i>3/31/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>ALLOUPE</i>		23d. LOCATION (City or Town) (County) (State) <i>GREEN BAY MD</i>	
24. FUNERAL DIRECTOR <i>Will Chambers Co Inc. GEORGETOWN</i>		25a. REC'D BY REGISTRAR <i>MAR 31 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

03760

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03730

CERTIFICATE OF DEATH

03724

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 5 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 3618 Gleneagles Dr. Apt. 7-2E	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Adelaide First Charlotte Middle Barker Last		4. DATE OF DEATH Month Mar. Day 10 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-39
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward H. Barker		14. MOTHER'S MAIDEN NAME Emily S. Gregory	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579-22 9028A	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO 4201 (b) Arteriosclerotic - Coronary Heart Disease DUE TO Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 66 to March 10 , 19 67 , that (I) (we) last saw the deceased alive on March 1 , 19 67 , and that death occurred at 6:40 am from causes and on the date stated above.			
22a. SIGNATURE Robert A. Yates		22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. R.A. Yates		22d. ADDRESS OLNEY, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/13/67	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR JOS GAWLER'S SONS, 5130 WIS. AVE. NW, WASH, D.C.		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judet			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03731

CERTIFICATE OF DEATH

03725

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> <u>16-2</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>		d. STREET ADDRESS <u>19 M Ridge Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>A. (Initial only)</u> Last <u>Baron</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> , Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 December 1919</u> <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>
13. FATHER'S NAME <u>Samuel Baron</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Ann Bluman</u>	
16. SOCIAL SECURITY NO. <u>114-12-2316</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>1967</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Open biopsy (R) Femur</u> DUE TO (c) <u>Chondrosarcoma (R) Femur head</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>3 Weeks</u> <u>7 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from <u>March 8</u> , 19 <u>67</u> , to <u>March 20</u> , 19 <u>67</u> , that the (we) last saw the deceased alive on <u>March 20</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> <u>PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John Dae Harrah</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>21 March 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Dae Harrah, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden Falls Church</u>	23d. LOCATION (City or Town) (County) (State) <u>Va.</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein</u> <u>Hebrew Memorial Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Wash. DC 20012</u> DATE <u>MAR 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

555

1992

CLEAR with MEDICAL Deputy EXAMINER

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE GEORGES		c. LENGTH OF STAY IN 1b 2 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSPITAL		d. STREET ADDRESS 2119 Guilford Rd	
3. NAME OF DECEASED (Type or print) First Middle Last ALEXANDER (NONE) BARONI-SE		4. DATE OF DEATH Month Day Year 3 24 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-23
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mgr. new 44 Restaurant		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (County & State, or foreign country) Brentwood, MD.		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME Alexander Baroni		14. MOTHER'S MAIDEN NAME Lucy Ragusa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NAVY WW2		16. SOCIAL SECURITY NO. UNAVAILABLE	
17. INFORMANT MRS IRENE V. BARONI		Address 2119 Guilford Rd. Hyattsville, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myelogenous leukemia (blast) 1 1/2 yrs crisis (c)			INTERVAL BETWEEN ONSET AND DEATH =
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11 , 19 65 to 3-24 , 19 67 , that (I) (we) last saw the deceased alive on 3-23 19 67 , and that death occurred at 1 PM , from causes and on the date stated above.			
22a. SIGNATURE Gilbert B. Cushe		22b. DATE SIGNED 3-24-67	
22c. PHYSICIAN'S NAME (Type) F. Gasch's Sons		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR MAR 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

03730

GEORGE W. BROWN

03730

Protonia
Vulgaris (L.)
China

3-21-61

19

11

3-23-61

Robert D. C. C. C.

3-24-61

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

03733

CERTIFICATE OF DEATH

03728

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY in 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>68 HOLY CROSS HOSPITAL</u>			d. STREET ADDRESS <u>9116 GEORGIA AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RALEIGH</u> Middle <u>R.</u> Last <u>BAUM</u>			4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1967</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-89</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treasury</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Clark County, Iowa</u>	
13. FATHER'S NAME <u>Frederick Baum</u>			14. MOTHER'S MAIDEN NAME <u>Alice Lowry</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>220-40-4852</u>		17. INFORMANT <u>Mrs. Ella Mae Goddard</u> Address <u>3610 St Barnabas Rd Silver Hill, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobular bilateral</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Emphysema, chronic, severe</u> DUE TO (c) <u>Pulmonary fibrosis</u> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>known</u> <u>2 years</u> <u>known</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 25</u> , 19 <u>54</u> , to <u>March 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 16</u> , 19 <u>67</u> , and that death occurred at <u>4:50</u> P.M. from causes on and on the date stated above.					
22a. SIGNATURE <u>Claron H. Traumm</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>March 17 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traumm</u>		22d. ADDRESS <u>8237 Georgia Ave - Silver Spring, Montgomery</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		ADDRESS <u>8434 Georgia Avenue</u>	25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1550

2550

1

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03729

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>Do A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> 16-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>12901 Forest View Dr. St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Heather Suzanne Baumgardt</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>Fe-</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/13/66</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Washi. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hans Edward Baumgardt Jr</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Eyre</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hans Baumgardt Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				22. DATE SIGNED <u>3/4/67</u>			
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		23d. LOCATION (City or Town) (County) (State) <u>Highland, Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc. 8434 Ga., Ave., S.S., Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6-47

03735

CERTIFICATE OF DEATH

03730

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>157</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1215 Edmonston Drive</u>		d. STREET ADDRESS <u>1215 Edmonston Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Arturs</u> First <u>Baumhammers</u> Middle <u>Edmonston</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mr. Red Cross</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>74</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alberts Baumhammers</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Tiesenbergs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margrieta A. Baumhammers - wife</u>		Address <u>item #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured aneurysm, right internal carotid artery</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u> <u>7 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1965</u> , to <u>Mar. 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar. 25, 1967</u> , and that death occurred at <u>1:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Sidney J. Cohen</u>		22b. DATE SIGNED <u>Mar. 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sidney J. Cohen</u>		22d. ADDRESS <u>50 W. Edmonston Drive, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>Rock Pike</u> <u>Rockville, Md.</u>	25a. REC'D BY REGISTRAR <u>DATE MAR 31 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0550

1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03736					03731					
Item #11 Film #0357 4/1/67 pc										
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase					b. COUNTY MONTGOMERY					
c. LENGTH OF STAY IN 1b 2 mo. 19 days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3708 Washington St.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BETHESDA SILVER SPRING NURSING HOME					d. STREET ADDRESS Kensington, Md.					
3. NAME OF DECEASED (Type or print) First Middle Last JULIA S. BEAN					4. DATE OF DEATH Month Day Year March 18 19 67					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1889		9. AGE (In years last birthday) 77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Govt.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Missouri/ Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Truman I. Milstead					14. MOTHER'S MAIDEN NAME Annie M. Milstead					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no					16. SOCIAL SECURITY NO. none					
17. INFORMANT Mrs. Doris C. Quigley					Address 4515 Avondale Bethesda, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases Carcinoma 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Bronchogenic Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 Mos. 9 Mos.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1960, 19 to March 18, 19 67, that (I) (we) last saw the deceased alive on May 16, 19 67, and that death occurred at 2:15 P.M. from the causes and on the date stated above.										
22a. SIGNATURE George Sharpe					22b. DATE SIGNED March 18, 1967					
22c. PHYSICIAN'S NAME (Type) GEORGE SHARPE					22d. ADDRESS 10400 Conn. Ave. Kensington, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF March 21, 67		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City, town or county) (State) Gaithersburg, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY					ADDRESS BETHESDA, MARYLAND		25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10780

0338

03737

CERTIFICATE OF DEATH

03732

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Connecticut b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 27 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westport 15-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 130 Hillandale Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Herbert Middle Simon Last Beardsley		4. DATE OF DEATH Month March Day 5 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 August 1906
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (County & State, or foreign country) Connecticut
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Beardsley	
14. MOTHER'S MAIDEN NAME Pauline Bohl		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 090-01-4723		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Myelogenous Leukemia DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6 February, 1967 , to 5 March, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5 March, 1967 , and that death occurred at 8:00 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Dr. Charles L. Vogel		22b. DATE SIGNED 5 March 1967	
22c. PHYSICIAN'S NAME (Type) Charles L. Vogel, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 3/6/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, 5130 N.W. AVE., N.W., WASH., D.C.		25a. REC'D BY REGISTRAR MAR 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03738

CERTIFICATE OF DEATH

03733

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d. STREET ADDRESS <u>6004 Marquette Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anne</u> First <u>E. BELLAR</u> Middle Last		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1896</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Cook, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Elenz</u>		14. MOTHER'S MAIDEN NAME <u>Marie Jacobs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>271-18-7915</u>	
17. INFORMANT <u>Terrace</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction with congestive heart failure</u> DUE TO (b) <u>failure</u> DUE TO (c) <u>failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 23</u> , 19 <u>67</u> , to <u>Mar. 1</u> , 19 <u>67</u> that (2) (we) lost saw the deceased alive on <u>Mar. 1</u> , 19 <u>67</u> , and that death occurred at <u>850AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. J. Kinney</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>R. J. KINNEY, M.D.</u>		22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>	
22b. DATE SIGNED <u>2 Mar. 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery, Ohio</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>CHAR 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08733

DEPARTMENT OF HEALTH

08733

STATE OF NEW YORK
IN SENATE
January 1, 1914
REPORT OF THE
COMMISSIONER OF HEALTH
ON THE
ADMINISTRATION OF THE
DEPARTMENT OF HEALTH
DURING THE YEAR
1913
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1914

03739

CERTIFICATE OF DEATH

03734

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15.1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>5702 Anniston Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Paul</u> Last <u>Benson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1901</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>solidw home Purchasing, Inc</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>R. J. Benson</u>	
14. MOTHER'S MARDEN NAME <u>Elizabeth Murphy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>578-07-4586</u>	
16. SOCIAL SECURITY NO. <u>578-07-4586</u>		17. INFORMANT Address <u>5702 Anniston Rd - Bethesda, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO (b) <u>1621</u> DUE TO (c) <u>Prostatic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Carcinoma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 1964</u> to <u>3/25/1967</u> , that (I) (we) last saw the deceased alive on <u>3/24/1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert U. Macon</u>		22b. DATE SIGNED <u>3/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert U. Macon, M. D.</u>		22d. ADDRESS <u>809 Viers Mill Rd Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Meth. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattstown, Maryland</u>
24. FUNERAL DIRECTOR <u>Donald M. M. R. Etchison & Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08739

08739

08739

Form with multiple sections and fields, including a large table area with columns and rows. The text is faint and mostly illegible due to the quality of the scan. There are two punch holes on the right side of the page.

FOR STATE
HEALTH DEPT.

03740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03735

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hospital</u>		d. STREET ADDRESS <u>1224 Dale Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>William C. Betson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-16</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Supt Building</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry C. Betson</u>		14. MOTHER'S MAIDEN NAME <u>Sally W. Fields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW2 (Army)</u>		16. SOCIAL SECURITY NO. <u>Frances G. Fields (sister)</u>	
17. INFORMANT <u>Frances G. Fields</u> Address <u>Dickerson, Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to nasal hemorrhage</u> DUE TO (b) <u>with aspiration of blood</u> DUE TO (c) <u>with aspiration of blood</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Deceased fell & fractured nose which bled</u>	
23. TIME OF INJURY Month, Day, Year Hour a.m. <u>9:00</u> <u>3-19</u> <u>1967</u>		24. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		26. (City or town) <u>Silver Spring</u> (County) <u>Montg. Md.</u> (State) <u>Md.</u>	
27. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
28. ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
30. EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>		31. ADDRESS (City or town) <u>Beallville</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>3/22/67</u>	
34. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		35. LOCATION (City or town) <u>Beallville</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
36. FUNERAL DIRECTOR <u>Constance C. Hilton</u>		37. ADDRESS <u>Barnesville Md.</u>	
38. REC'D BY REGISTRAR <u>MAR 27 1967</u>		39. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

03741

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03736

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY in 1b <u>1 1/2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH-SAN-HOSPITAL</u>				d. STREET ADDRESS <u>1056 RUATAN ST.</u>			
3. NAME OF DECEASED (Type or print) <u>(R.) EDWARD PRESTON BIRKHEAD</u>				4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-64</u>	
9. AGE (In years lost birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD PRESTON BIRKHEAD, SR</u>				14. MOTHER'S MAIDEN NAME <u>Sandra Harris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward Edward Birkhead</u>		Address <u>1056 Ruatan Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 082.3 IMMEDIATE CAUSE (a) <u>Acute, severe, viral encephalitis and</u> DUE TO (b) <u>markedly severe mesenteric adenitis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County or State) <u> </u>							
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>3/25/1967</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 29 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

28760

Figure 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

<div> <div> <div>5</div> <div>1</div> </div> <div> <div>Items 18&21 Film 388 5-9-</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> </div> <div> <div>03742</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03737</div> </div>											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 7719 Eastern Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph Evans Bloom						4. DATE OF DEATH Month Day Year 3 18 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/09		9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plasterer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk, Va.				12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Isaac D. Bloom						14. MOTHER'S MAIDEN NAME --					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-01-0976		17. INFORMANT Doris Bloom/wife				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute right coronary thrombosis DUE TO (b) Arteriosclerotic heart disease DUE TO (c) lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 3/19/1967			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/22-67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Frank W. Leaty, 814 W. 36th St., Balto., Md.						25. REC'D BY REGISTRAR MAR 22 1967		25a. REGISTRAR'S SIGNATURE [Signature]			

08137

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08137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03743

CERTIFICATE OF DEATH

03738

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. & HOSPITAL</u>		d. STREET ADDRESS <u>12418 North Capitol St.</u>	
3. NAME OF DECEASED (Type or print) <u>Evelyn C. Bodwell</u>		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-71</u>
9. AGE (In years lost birthday) <u>96</u> YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Gonn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Clayton</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE PECK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bladder tumors (Ca) with obstruction of ureters</u> DUE TO <u>Probable kidney tumor on the left.</u> (b) <u>Involvement of kidneys with renal insufficiency and uremia</u> DUE TO <u>Myocardial insufficiency with congestive failure</u> (c) <u>Mild diabetes mellitus</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Few days</u> <u>1 week</u> <u>months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/15/67</u> , 19 <u>67</u> , to <u>3/30/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/30/1967</u> , and that death occurred at <u>1:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas H W. Lohon</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H W. Lohon</u>		22d. ADDRESS <u>7401 Blair Rd. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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08080

RECORD OF DEEDS

RECORD OF DEEDS

RECORD OF DEEDS

RECORD OF DEEDS

03744

CERTIFICATE OF DEATH

03739

4
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

1

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CABIN JOHN, Md. 15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>7409 ARDEN RD.</u>			
3. NAME OF DECEASED (Type or print) <u>MARGARET ANN Bello</u>				4. DATE OF DEATH <u>MAR. 23, 1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 18, 1922</u> 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MONT. CO. BOARD EDUC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PATROL GUARD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PATRICK KEADY</u>				14. MOTHER'S MAIDEN NAME <u>MAY WHITE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Joseph Bolla Jr.</u> Address <u>CABIN JOHN MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Breast - Bilateral</u> DUE TO (b) <u>Breast - Bilateral</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 8, 1962</u> , to <u>Mar. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar. 21, 1967</u> , and that death occurred at <u>2:40 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Robert G. Brewer</u> M.D.				MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>				22d. ADDRESS <u>8505 Old Georgetown Rd. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6150

252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03745

CERTIFICATE OF DEATH

03740

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>			c. LENGTH OF STAY in 1b <u>1 week</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>12327 JUDSON ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Jane</u> Last <u>Bort</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1912</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Alvin J. Hitchcock</u>				14. MOTHER'S MAIDEN NAME <u>Carrie L. Daum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Husband</u> <u>Artemas R. Bort</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1562</u> <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO (b) <u>METASTATIC CARCINOMA OF LIVER</u> DUE TO (c) <u>PRIMARY UNDETERMINED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MUSCULAR DYSTROPHY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR. 2, 1967</u> , to <u>MARCH 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 6, 1967</u> , and that death occurred at <u>7:10 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Angle</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MAR. 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>				22d. ADDRESS <u>5009 Del Ray Ave.</u> <u>Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CENTRAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03746

CERTIFICATE OF DEATH

03741

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN lb 33 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 14207 Avery Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Mae Boyd First Middle Last		4. DATE OF DEATH March 20 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/25
9. AGE (In years lost birthday) 42 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley Gibbs		14. MOTHER'S MAIDEN NAME Johnsie Carol	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records, Olney, Maryland Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary Anemia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Cervix with metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 dy	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/1/65 to 3/20/67 , that (I) (we) last saw the deceased alive on March 20 1967 , and that death occurred at 6:30 p.m. from causes on and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 3/23/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Ligon		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Mar 24 1967	23c. NAME OF CEMETERY OR CREMATORY John Wesley Cemi.	23d. LOCATION (City or town) (County) (State) Clarksburg Montg Md.
24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.		25a. REC'D BY REGISTRAR MAR 23 1967	25b. REGISTRAR'S SIGNATURE [Signature]

10780

CERTIFICATE OF DEATH

10780

Handwritten text, likely a signature or name, possibly "The Great ..."

10780

Handwritten signature or initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03747

CERTIFICATE OF DEATH

03742

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 78 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 8613 Irvington Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Douglas Last BRADBURY		4. DATE OF DEATH Month March Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1918
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Brookline, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Royall Douglas Bradbury		14. MOTHER'S MAIDEN NAME Agatha Carney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1940-1960		16. SOCIAL SECURITY NO. 142-18-0852	
17. INFORMANT Bethesda, Maryland Mrs. Lillian Bradbury, 8613 Irvington Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Laennec's Cirrhosis IMMEDIATE CAUSE (a) 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5811 DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 16		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 18 , 19 67 , to Mar. 6 , 19 67 , that (X) (we) last saw the deceased alive on Mar. 6 , 19 67 , and that death occurred at 135A M, from causes and on the date stated above.			
22a. SIGNATURE Elliott Perlin		22b. DATE SIGNED Mar. 6, 1967	
22c. PHYSICIAN'S NAME (Type) Elliott Perlin, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR Joseph Gawler & Son 5130 Wisconsin Ave., N.W., Washington, D.C.		25a. REC'D BY REGISTRAR MAR 13 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03748

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>5400 Pooks Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edward Leo Brady</u>			4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1887</u>	9. AGE (In years and months) <u>79</u> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR UNDER 24 HRS. <input type="checkbox"/> Months <u>21</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Republic Bank</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>	
13. FATHER'S NAME <u>John Brady</u>			14. MOTHER'S MAIDEN NAME <u>Anna Craven</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579 12 7657</u>		17. INFORMANT <u>Thelma McGuire (Sister)</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Inf. old & recent</u> DUE TO (b) <u>Coronary Atherosclerosis, severe</u> DUE TO (c) <u>24 hrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>John G. Ball, M. D.</u>		22. DATE SIGNED <u>3/22/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. Washington, D. C.</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03749

CERTIFICATE OF DEATH

03744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>112 Indian Spring Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>A</u> Last <u>Brecht</u>		4. DATE OF DEATH <u>3/24/67</u> Month <u>19</u> Day <u>19</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/24</u> 9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of U.S. Govt. Eng.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Brecht</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Plant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-60-0681</u> Yes	
17. INFORMANT <u>Mary A. Sweeney</u> Address <u>112 Indian Spring Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Advanced Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Moderate Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>67</u> to <u>3/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> , 19 <u>67</u> , and that death occurred at <u>7:17</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis X. Richardson</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson, M.D.</u>		22d. ADDRESS <u>11412 Viers Mill Rd., Wheaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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03750

CERTIFICATE OF DEATH

03745

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maplewood	
c. LENGTH OF STAY IN 1b 180 days		d. STREET ADDRESS 121 Oak View Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, NIH, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Morris Middle (NMN) Last Brenman		4. DATE OF DEATH Month March Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 March 1906
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Local government	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Brenman		14. MOTHER'S MAIDEN NAME Anna Freedman Stahl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Records, The Clinical Center, National Institutes of Health, Bethesda, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 1939 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Edema DUE TO (c) Glioblastoma Multiforme		INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 September 1966 , to 25 March, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 25 March 1967 , and that death occurred at 10:30 AM , from causes and on the date stated above.			
22a. SIGNATURE I. David Goldman M.D.		22b. DATE SIGNED 25 March 1967	
22c. PHYSICIAN'S NAME (Type) I. David Goldman, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY Temple Emanuel Cem.	23d. LOCATION (City or Town) (County) (State) New Jersey
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR St. Wash. D.C.	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03751

CERTIFICATE OF DEATH

03746

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 5 years		d. STREET ADDRESS 714 Sligo Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 714 Sligo Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alonzo Frank Bruffy First Middle Last		4. DATE OF DEATH March 26 19 67 Month Day Year	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 28, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired operator		10b. KIND OF BUSINESS OR INDUSTRY Variety Store	
11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonzo Bruffy		14. MOTHER'S MAIDEN NAME Martha Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 578-26-5285	
17. INFORMANT Drene Bruffy		Address 714 Sligo Avenue Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF ABDOMINAL ANEURYSM DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 YRS. (c) 5 YRS.		INTERVAL BETWEEN ONSET AND DEATH 5 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-9, 1967 to 3-21, 1967 , that (I) (we) last saw the deceased alive on 3-21, 1967 , and that death occurred at 11 A.M. from causes on and on the date stated above.			
22a. SIGNATURE L.B. Snow		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) L. B. Snow		22d. ADDRESS 7950 N. H. Ave., Langley Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR John B. Thomas & Son, Inc.		25a. REC'D BY REGISTRAR 30 1967	
ADDRESS 434 Georgia Avenue Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03752						03747					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Opkey</u> c. LENGTH OF STAY IN 1b <u>9 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grace Foundation</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Rebecca Belle</u> First Middle Last		4. DATE OF DEATH <u>March 7</u> Month Day Year		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1883</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Parsley</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Janglells</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>W. Russell Bryan</u> Address <u>Brookeville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ISCHEMIC HEART DISEASE</u> (c) <u>ARTERIO SCLEROTIC C.V. DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>YRS.</u> <u>YRS. 1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>OLD STROKE - HEMI PLEGIA</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1963</u> to <u>3/7</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Donald R. Lewis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-8-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>DONALD R LEWIS</u>				22d. ADDRESS <u>OLNEY MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville</u>		23d. LOCATION (City, town or county) (State) <u>Burtonsville, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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Reviews

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Robert H. Roberts

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03753

CERTIFICATE OF DEATH

03748

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b Fulton, Md. 13.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Lime Kiln Road	
3. NAME OF DECEASED (Type or print) Inga		4. DATE OF DEATH Month Mar. Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 16 1896
9. AGE (In years lost birthday) yrs. 70		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johanne Gunderson		14. MOTHER'S MAIDEN NAME Christine Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Montgomery Gen. Hospital		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 1538 DUE TO Metastatic Adenocarcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mo (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8 , 19 66 to 3/21 , 19 67 , that (I) (we) last saw the deceased alive on 13.07 , and that death occurred 13.07 M, from causes and on the date stated above.			
22a. SIGNATURE C.H. LUGOW		22b. ADDRESS SANDY SPRING, MD.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-23-67	
23c. NAME OF CEMETERY OR CREMATORY St Louis Cem		23d. LOCATION (City or Town) (County) (State) Clarksville Md	
24. FUNERAL DIRECTOR Robert Donaldson		25. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03754

CERTIFICATE OF DEATH

03749

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014				d. STREET ADDRESS Franklin Manor, Essex Street			
3. NAME OF DECEASED (Type or print) First Middle Last Sandra Lee Burke		4. DATE OF DEATH Month Day Year March 11 19 67		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 February 1944		9. AGE (In years lost birthday) yrs. 23		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ward Clerk		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. Burke				14. MOTHER'S MAIDEN NAME Dorcas Hunt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not Available		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Cerebral Edema DUE TO (c) Acute Myelogenous Leukemia						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 24 hours 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10 February, 19 67 , to March 11, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 March 19 67 , and that death occurred at 12:25 A.M. , from causes and on the date stated above.							
22a. SIGNATURE C. Kierney		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> A.M.		22b. DATE SIGNED 11 March 1967			
22c. PHYSICIAN'S NAME (Type) Carl E. Kierney, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Ives Funeral Home		ADDRESS 2847 Wilson Boulevard Arlington, Virginia		25a. REC'D BY REGISTRAR MAR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03755

CERTIFICATE OF DEATH

03750

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 10 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 15710 NEW COLUMBIA PIKE	
3. NAME OF DECEASED (Type or print) First MINNIE Middle MAUDE Last BURTON		4. DATE OF DEATH Month 3 Day 31 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-97
9. AGE (In years, last birthday) 69 yrs.		IF UNDER 1 YEAR Months 3 Days 31 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Name	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EVAN GAITHER		14. MOTHER'S MAIDEN NAME CARRIE MURPHY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEDICAL RECORDS DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/31 , 1967, to 3/31 , 1967, that (I) (we) just saw the deceased alive on 3/31 , 1967, and that death occurred at 9:50 AM , from causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-67	
23c. NAME OF CEMETERY OR CREMATORY Arrian Cem		23d. LOCATION (City or Town) (County) (State) Burtonsville Md	
24. FUNERAL DIRECTOR De Witt Donaldson Laurel, Md		25a. REC'D BY REGISTRAR APR 5 1967	
25b. REGISTRAR'S SIGNATURE W. Hamm and		25c. REGISTRAR'S SIGNATURE J Charles Judge	

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STATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03751

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cleveland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>936 - Ida St.</u>	
3. NAME OF DECEASED (Type or print) <u>Irene Helen Basinski</u>		4. DATE OF DEATH <u>March 25 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1917</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph W. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Stella Louda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wm. F. Basinski</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis Old & Recent</u> DUE TO (c) <u>Cardio Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>3/26/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial-Transit</u>	<u>3-27-67</u>	<u>Calvary Cemetery</u>	<u>Cleveland, Ohio</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03751

03750

Myocardial Infarction
Coronary Thrombosis with Recanalization
Coronary Vessel Disease

John B. Rose

8/10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~the~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03757

03752

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 11-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN., + HOSPITAL		d. STREET ADDRESS 1238 VAN BUREN ST., NW	
3. NAME OF DECEASED (Type or print) ANNA First Middle Last		4. DATE OF DEATH MAR. 7, 1967 Month Day Year	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/89
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ROMANIA		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME SAMUEL SIEGEL		14. MOTHER'S MAIDEN NAME CLARA MERGLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial Infarction DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-3, 1967 to 3-7, 1967 , that we (we) last saw the deceased alive on 3-7, 1967 , and that death occurred at 8:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Gilbert B. Cushner M.D.		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) Gilbert B. Cushner		22d. ADDRESS 11161 New Hamp. Ave. S.S.Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/9/67	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gar.	23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia
24. FUNERAL DIRECTOR B. Nauzansky & Sons		25a. REC'D BY REGISTRAR DATE MAR 9 1967	
ADDRESS 3501-14th St. N.W.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

03752

STATE OF TEXAS

03752

Myocardial Infarction
Cerebral Anoxia

3-7-67 3-7-67 3-7-67

3-7-67

3-7-67

X

Robert B. Walsh

Robert B. Walsh

Robert B. Walsh

Robert B. Walsh

03758

CERTIFICATE OF DEATH

03753

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN lb 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY NURSING HOME POTOMAC VALLEY RD.		d. STREET ADDRESS 11807 Gainesborough Rd.	
3. NAME OF DECEASED (Type or print) EVELYN First ROSE Middle CARROLL Last		4. DATE OF DEATH Month MARCH Day 7 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Sept. 21 1898 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John G. Carter		14. MOTHER'S MAIDEN NAME Theresa V. Farrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-52-5786	
17. INFORMANT Daughter Address Same as Item 2. Mrs. H.S. Higdon			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 60 , to 3-7 , 19 67 , that (II) (we) last saw the deceased alive on 3-7-67 19____, and that death occurred at 11:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Morris Perry		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) MORRIS PERRY		22d. ADDRESS 11602nd Georgia Ave. Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-10-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery, Arlington, Va.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

62580

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FOR STATE HEALTH DEPT.

03759

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03754

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9511 Linoak Drive</u>		d. STREET ADDRESS <u>9511 Linoak Drive</u>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE R. CARSON</u>		4. DATE OF DEATH <u>3-29-67</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1894</u>
9. AGE (In years, last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>EDWARD H. RIAL</u>		14. MOTHER'S MAIDEN NAME <u>LILIA R. KRAFT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>		16. SOCIAL SECURITY NO. <u>091-22-8110</u>	
17. INFORMANT <u>Richard E. Carson</u>		Address <u>Kensington, Md. 9803 CULVER ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>330 X</u> IMMEDIATE CAUSE (a) <u>Massive left subarachnoid hemorrhage</u> DUE TO (b) <u>accompanied by chronic myelocytic leukemia</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>3/29/1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-31-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		DATE <u>APR 3 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05724

92560

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03760					03755				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Hampshire</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Woodstock</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17508 Redland Road</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OSCAR</u> First <u>B.</u> Middle <u>CARTER</u> Last			4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/28/93</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire - Errol</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ira Carter</u>					14. MOTHER'S MAIDEN NAME <u>Helen B. Straw</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>001-09-1311</u>		17. INFORMANT <u>Herbert M. Carter</u>		17508 Redland Road Rockville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4301</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CORONARY ARTERY DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>30 YEARS</u> <u>20 YEARS</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC RENAL FAILURE - PULMONARY EMPHYSEMA</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 7, 1966</u> to <u>MARCH 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 1, 1967</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 3, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger, M. D.</u>					22d. ADDRESS <u>310 West Montgomery Ave. Rockville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>			23b. DATE THEREOF <u>3/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodstock</u>		23d. LOCATION (City, town or county) (State) <u>Woodstock, New Hampshire</u>		
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> <u>Funeral Home-1331 Rockville Pike Rockville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>		

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09755

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03761

CERTIFICATE OF DEATH

03756

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO. MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 2 days/14 hrs/45 min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN + HOSPITAL		d. STREET ADDRESS 6805 WOODLAND AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara First NONE Middle CARUSI Last		4. DATE OF DEATH March 7, 1967 Month 7 Day 7 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-12
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (County & State, or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hall		14. MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213 40 7708	
17. INFORMANT Hospital Records		Address 7600 Carroll Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 330X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO ruptured aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 days (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 3 (this hospital) attended the deceased from 3-5, 1967 to 3-7, 1967 , that 4 (we) last saw the deceased alive on 3-7 19 67 and that death occurred at 7 PM , from causes and on the date stated above.			
22a. SIGNATURE Gilbert B. Cushner M.D.		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) GILBERT B. CUSHNER		22d. ADDRESS 11161 New Hamp Ave. Sd Sp Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colman Manor Pk Co Md	
24. FUNERAL DIRECTOR Arthur Waters		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03520

0330

Future analysis

Robert B. Wright
3-5-67

3-2-70

3-2
7/17/9

— Chas. B. Webb.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03762

CERTIFICATE OF DEATH

03758

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN lb 13 DAYS		d. STREET ADDRESS 122 Ritchey Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA KATHERINE CLARK		4. DATE OF DEATH Month MARCH Day 12 Year 1967	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/92
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES B. KIRK		14. MOTHER'S MAIDEN NAME Ida Bealle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest. DUE TO (b) Myocardial ischemia DUE TO (c) Severe Rt & Lt. Heart Failure			
INTERVAL BETWEEN ONSET AND DEATH 1 Hour Day? Month.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Failure Cor Pulmonale; Possible CNS Disease; Diabetes; Congestive Heart			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from Feb 28 , 1967, to Mar 12 , 1967, that (1) (we) last saw the deceased alive on Mar 12 , 1967, and that death occurred at 10 P. M. from causes and on the date stated above.			
22a. SIGNATURE Welford D. Meyers MD.		22b. DATE SIGNED Mar 13, 1967	
22c. PHYSICIAN'S NAME (Type) Welford D. Meyers MD.		22d. ADDRESS 8323 Haddon Dr. Takoma Park Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/15/1967	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION (City or Town) (County) (State) SIL. SPRING MONTGOMERY MD.
24. FUNERAL DIRECTOR W.W. CHAMBERS, Inc.		25a. REC'D BY REGISTRAR MAR 14 1967	
ADDRESS SILVER SPRING		25b. REGISTRAR'S SIGNATURE Charles Judge	

S2560

03528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03763					03759				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
a. COUNTY		Montgomery			a. STATE		b. COUNTY		
		MARYLAND			Maryland		Montgomery		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b					
Chevy Chase									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
19 Grafton Street					19 GRAFTON STREET				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
NAYAN IDA COBB					March 10 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Female		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/25/85		81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
School Principal - Chevy Chase				Country day Sch.		Toronto, Canada		U.S.A.	
13. FATHER'S NAME					MOTHER'S MAIDEN NAME				
- Whitlam					Unobtainable				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
no					215-34-3281		Stanwood Cobb same as above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)									
157X Carcinoma of pancreas, with Metastases									
DUE TO									
Conditions, if any, which gave rise to immediate cause (b)									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
Left - Hemiplegia									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour o.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Nov 4, 1964, to Mar 10, 1967, that (I) (we) last saw the deceased alive on Mar 4, 1967, and that death occurred at 8:45 AM, from the causes and on the date stated above.									
22a. SIGNATURE									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Frank S. Bacon									
22d. ADDRESS									
2141-K-ST. N.W.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
Burial									
23b. DATE THEREOF									
3/13/67									
23c. NAME OF CEMETERY OR CREMATORY									
Rock Creek Cemetery									
23d. LOCATION (City, town or county) (State)									
Washington, D. C.									
24. FUNERAL DIRECTOR'S SIGNATURE									
The S. H. Hines Company Washington, DC									
25. REC'D BY REGISTRAR									
MAR 13 1967									
25b. REGISTRAR'S SIGNATURE									
J. Charles Judge									

03759

03759

CENTRAL IN STATE

1000

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03764

CERTIFICATE OF DEATH

03760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6400 - Brookville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Thomas Cochran</u>		4. DATE OF DEATH <u>March 13 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Lodge Cochran</u>		14. MOTHER'S MAIDEN NAME <u>Whitacre</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes - U.S. Army</u>		16. SOCIAL SECURITY NO. <u>449-46-1618</u>	
17. INFORMANT <u>Robert Thomas Cochran Jr.</u>		Address <u>See Item 18</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>13 Mar 1967</u> , that (I) (we) last saw the deceased alive on <u>13 Mar 1967</u> , and that death occurred at <u>11:00 p.m.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>H. A. Grennan</u>		22b. DATE SIGNED <u>13 Mar 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. A. GRENNAN</u>		22d. ADDRESS <u>2001 Eye St N.W. Wash., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>3-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Alexandria Nat'l. Cem. Alexandria, Va.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash.D.C.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1952

2050

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>9609 Avenel Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>PAULINE</u> Last <u>COHN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/4/1891</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>76</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Jacob Keroes</u>				14. MOTHER'S MAIDEN NAME <u>Rosa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Stern - 9609 Avenel Rd., Sil. Sp., Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CardioVascular Disease</u> DUE TO (c) <u>4201</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>3/22/67</u>	
EXAMINER'S NAME (Type) <u>Bernard Danzansky & Sons</u>		23b. DATE THEREOF <u>3/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Heb. Cong. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Heb. Cong. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons St. NW, Wash. D.C.</u>		ADDRESS <u>3501-14th</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03582

03581

Corporal Ernest A. Smith
Carroll County, Texas

John A. Jones

Operator

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03766		CERTIFICATE OF DEATH				03762				
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seaboard</u>					d. STREET ADDRESS <u>4944 - Hampden Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Antigone Nicholas (Mrs)</u>					4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>7 JUNE 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Turkey</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Demetris Nicholas</u>					14. MOTHER'S MAIDEN NAME <u>MERSINI (UNKNOWN)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Constantine Cois</u> Address <u>same as above</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X CEREBRAL VASCULAR ACCIDENT (2ND)</u> DUE TO (b) <u>CEREBRAL VASCULAR ACCIDENT (1ST)</u> DUE TO (c) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>1 WEEK</u> <u>AT LEAST 10 YEARS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) ACUTE CONGESTIVE CARDIAC FAILURE (2) UREMIA.</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>66</u> , to <u>MARCH 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 22</u> , 19 <u>67</u> , and that death occurred at <u>8 P</u> M, from causes and on the date stated above.										
22a. SIGNATURE <u>Nicholas Madeloff</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Nicholas Madeloff</u>					22d. ADDRESS <u>10620 GEORGIA AVE. SILVER SPRING MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>25 MAR 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY BLADENSBURG MD.</u>			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME INC</u>				ADDRESS <u>7700 GEORGIA AVE NW</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		

03780

03780

OF THE 12 OF DEATH

73

CEREBRAL VASCULAR ACCIDENT (2nd)

CEREBRAL VASCULAR ACCIDENT (1st)

HYPERTENSIVE (BRAIN VASCULAR DISEASE)

(1) ACUTE CONGESTIVE (CARDIAC FAILURE) (2) UREMIA

No

March 22, 1930

March 22, 1930

Walter R. Murphy

X

10000 General Ac. Ins. Co. Inc.

March 22, 1930

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Wheaton)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Howard Johnson Motel</u>		d. STREET ADDRESS <u>Box 130, Windsor Mill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>LLOYD E. CONTANT</u>		4. DATE OF DEATH <u>MARCH 25 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Rochester, N.Y.</u>
13. FATHER'S NAME <u>Wm. A. Contant</u>		14. MOTHER'S MAIDEN NAME <u>Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Maryon A. Contant</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, City, Town, or County)		22. DATE SIGNED <u>3/25/1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 30 1967</u>			

03780

03780

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03768

03764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN b. 6 months			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 417 Southwest Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ina First M. Middle Cook Last				4. DATE OF DEATH March 2 Month 1967 Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1883	
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk				10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (County & State, or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown Sandefur				14. MOTHER'S MAIDEN NAME Mary J. Nichols			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Earle Wallick Address 417 Southwest Drive Silver Spring, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 2 March , 19 67 , that (I) (we) last saw the deceased alive on 2 March , 19 67 , and that death occurred at 3:00 PM from the causes and on the date stated above.							
22a. SIGNATURE William And M.D.				22b. DATE SIGNED 3/2/67			
22c. PHYSICIAN'S NAME (Type) William And				22d. ADDRESS 9001 Colesville Rd., S. S., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF March 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Sterling Cemetery		23d. LOCATION (City, town or county) (State) Sterling, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Glen Carter ADDRESS 8434 Georgia Ave. Silver Spring, Md.				25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE MAR 6 1967							

03768

STATE OF TEXAS

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03769

CERTIFICATE OF DEATH

03765

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Chase Nsg. & Conv. Home</u> <u>2015 E. West Highway, Silver Spring, Md.</u>		d. STREET ADDRESS <u>8201 16th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Abbe</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptroller</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Nathan</u>		14. MOTHER'S MAIDEN NAME <u>Coplan, Celia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>577-03-0278</u>	
17. INFORMANT <u>Wife</u>		Address <u>8201-16th St. Sil Sp., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cessation Resp</u> DUE TO (b) <u>Cerebral thromboses</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19____, to <u>MARCH</u> , 1967, that (I) (we) last saw the deceased alive on <u>3/17/67</u> , 19____, and that death occurred at <u>2:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Milton Gussak</u>		22b. DATE SIGNED <u>3/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Milton Gussak, M.D.</u>		22d. ADDRESS <u>1302-18th NW, Wash. DC 20036</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ohav Sholom-Talmud Torah Cem.</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03780

03780

STATE OF OHIO

1887

03771

CERTIFICATE OF DEATH

03767

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 3006 DAWSON AVENUE	
3. NAME OF DECEASED (Type or print) First CARL Middle Dennis Last CRIST		4. DATE OF DEATH MARCH 23 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/00
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 23 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab.	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Crist		14. MOTHER'S MAIDEN NAME Lucy Fultz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 579-03-5124	
17. INFORMANT Dorothy Robinson		Address 3707 Delano Street Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2044 IMMEDIATE CAUSE (a) Serum Hepatitis DUE TO (b) Transfusion for Severe Anemia DUE TO (c) Leukemia		INTERVAL BETWEEN ONSET AND DEATH 1 week 9 mos. 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatic Inflammation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 3-13 , 19 67 , to 3-23-67 , 19 67 , that (I) (we) last saw the deceased alive on 3-23-67 , 19 67 , and that death occurred at 2:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Morris Perry		22b. DATE SIGNED 3-23-67	
22c. PHYSICIAN'S NAME (Type) Morris Perry		22d. ADDRESS 11602 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF Mar 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Stonewall Jackson Memorial		23d. LOCATION (City or Town) (County) (State) Lexington, Virginia	
24. FUNERAL DIRECTOR John B. Thomas		25a. REC'D BY REGISTRAR DATE 27 1967	
25b. REGISTRAR'S SIGNATURE John B. Thomas		25c. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0356

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G386 3/13/67 pv

CERTIFICATE OF DEATH

03772

03768

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN Tb 2 months		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home						d. STREET ADDRESS 2722 73rd Pl., Hyattsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Holmes Crocker						4. DATE OF DEATH Month 3 Day 3 Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/14/1889		9. AGE (In years last birthday) 78 7/9 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical engineer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Great Barrington, Mass.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Crocker						14. MOTHER'S MAIDEN NAME Nellie Holmes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI & WWII				16. SOCIAL SECURITY NO. 177-10-5245		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Nov 4 , 19 66 , to March 5 , 19 67 , that (I) (we) last saw the deceased alive on March 3 , 19 67 , and that death occurred at 6 P.M. , from causes and on the date stated above.											
22a. SIGNATURE William Brannin M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/3/67			
22c. PHYSICIAN'S NAME (Type) WM BRANNIN						22d. ADDRESS 6124 Central Ave, Capitol Heights					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 3/4/67		23c. NAME OF CEMETERY OR CREMATORY Lees Crematory		23d. LOCATION (City or Town) (County) (State) Washington D.C.			
24. FUNERAL DIRECTOR J. Wm. Lees Sons 300 4th St., NE. Wash., DC						25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

83560

5568

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~other~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03773

CERTIFICATE OF DEATH

03769

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillendale</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>				d. STREET ADDRESS <u>1600 Oakhawn Ct.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Lee Crummitt</u>				4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-09</u>	9. AGE (In years last birthday) yrs. <u>57</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Crupper</u>				14. MOTHER'S MARDEN NAME <u>Rose Hunt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Washington San & Hospital Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>603X</u> IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> DUE TO (b) <u>uremia</u> DUE TO (c) <u>kidney insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Jan. 16.67</u>
PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>- carcinoma of the liver.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , to <u>3-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-6-67</u> , and that death occurred at <u>4:45</u> P.M. from causes on and on the date stated above.							
22a. SIGNATURE <u>VERONICA TROOST</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST</u>				22d. ADDRESS <u>10236 N. H. Ave. S.S. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Warrenton</u>		23d. LOCATION (City or Town) (County) (State) <u>Warrenton, Jefferson, Va.</u>			
24. FUNERAL DIRECTOR <u>MOSE R FUNERAL HOME</u>				ADDRESS <u>WARRENTON, VA</u>		25a. REC'D BY REGISTRAR DATE <u>9</u> 1967	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03730

RECEIVED BY DEATH

03730

03774

CERTIFICATE OF DEATH

03770

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>3 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				d. STREET ADDRESS <u>1042 Rosemary Hills Dr.</u> <u>9100 New River Road, Silver Spring, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>Ware</u> Middle <u>Cushman</u> Last				4. DATE OF DEATH <u>Mar</u> Month <u>13</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 1893</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VERMONT</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John H. Ware</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Church</u> <u>XXXXXXXXXXXXXXX</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>070-20-0445</u>		17. INFORMANT <u>Elizabeth Arnold</u> Address <u>1942 Rosemary Hills Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>& Cardio vascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 29, 1967</u> to <u>Mar 13, 1967</u> that (I) (we) last saw the deceased alive on <u>3/13</u> 1967, and that death occurred at <u>11:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/13/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		22d. ADDRESS <u>2852 16 - 4th Wash D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Mar 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04560

4760

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03775

CERTIFICATE OF DEATH

03771

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland		c. LENGTH OF STAY IN lb 30 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorloo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS P.O. Box 48	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Eugene Last Davey		4. DATE OF DEATH March 5 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 March 1908
9. AGE (In years lost birthday) yrs. 58		IF UNDER 1 YEAR Months 11 Days 8 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	11. BIRTHPLACE (County & State, or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Davey	
14. MOTHER'S MAIDEN NAME Hilda Paulsen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes	
16. SOCIAL SECURITY NO. 564-18-4272		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO insufficiency and tricuspid insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Rheumatic heart disease; mitral stenosis and/ DUE TO tricuspid annuloplasty (c) Post-operative mitral valve replacement and/			INTERVAL BETWEEN ONSET AND DEATH 45 minutes 15 years 19 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from 3 February, 1967 , to 5 March, 1967 , that (X) (we) lost saw the deceased alive on 5 March 19 67 , and that death occurred at 11:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Hamner Hannah III		22b. DATE SIGNED 6 March 1967	
22c. PHYSICIAN'S NAME (Type) Hamner Hannah, III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-9-1967	23c. NAME OF CEMETERY OR CREMATORY MOUNT PEACE CEMETERY	23d. LOCATION (City or Town) (County) (State) MINERSVILLE, PENNA
24. FUNERAL DIRECTOR William M. Hysong ADDRESS WASH, D.C.		25a. REC'D BY REGISTRAR DATE MAR 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03778

CERTIFICATE OF DEATH

03778

1981

03776

CERTIFICATE OF DEATH

03772

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN lb 15-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8506 Bradmoor Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura Wise David First Middle Last		4. DATE OF DEATH MARCH 15 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-1873 9. AGE (In years last birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leo A. Wise	
14. MOTHER'S MAIDEN NAME Bertha Kohn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -	
16. SOCIAL SECURITY NO. 577-66-1290		17. INFORMANT Mr. Leo David - See Item # 2. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 15 YEARS		INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MULTIPLE SMALL STROKE SYNDROME		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/11/67 , 19 to 3/15/67 , that (I) (we) last saw the deceased alive on 3/11/67 , and that death occurred at 8:35 M, from causes and on the date stated above.			
22a. SIGNATURE Horace H. Custis Jr.		22b. DATE SIGNED 3/15/67	
22c. PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR.		22d. ADDRESS 1852 COLUMBIA RD NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-17-1967	23c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Congregation, Washington, D.C.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR Charles Judge DATE MAR 20 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03712

DEPARTMENT OF AGRICULTURE

03712

WASHINGTON, D.C. 20250

June 1, 1964

Mr. J. Edgar Hoover

Federal Bureau of Investigation

Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the

information received from the

Department of Justice regarding

the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03777

CERTIFICATE OF DEATH

03773

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg		13-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS ---	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARVIN Middle WILSON Last DAY		4. DATE OF DEATH Month 3 Day 10 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/87
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 3 Days 10 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua B. Day		14. MOTHER'S MAIDEN NAME Laura Hobbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-36-1922	
17. INFORMANT Hospital Records, Olney, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; coronary sclerosis			
INTERVAL BETWEEN ONSET AND DEATH 72 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from 11-2- , 19 46 , to 3-10- , 19 67 , that (I) was saw the deceased alive on 3-10- , 19 67 , and that death occurred at 6:00P M, from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		22b. DATE SIGNED 3-10-67	
22c. PHYSICIAN'S NAME (Type) Charles Whitaker, M.D.		22d. ADDRESS Clarksville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-13-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. View		23d. LOCATION (City or Town) (County) (State) Alpha, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE MAR 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

03773

03773

Chick & Martin
A.D.

CERTIFICATE OF DEATH

03778

03774

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUBURBAN BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>3 hrs 45 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10103 Huest St</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>M.</u> Last <u>DEADY</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years lost birthday) yrs. <u>78</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Worcester MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Burke</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Morrissey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Lucille Muller</u> daughter Address <u>SAME AS ABOVE</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>7 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>March 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 16</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u>		22b. DATE SIGNED <u>March 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane, Chevy Chase Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>3-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Bridget's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Plainville, Mass.</u>
24. FUNERAL DIRECTOR <u>Joe Rowlen Inc</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
26. ADDRESS <u>5130 Win Ave</u>		27. DATE <u>MAR 20 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03774

ESTIMATE OF DAMAGE

03774

PROPERTY OF THE UNITED STATES

DEPARTMENT OF THE ARMY

HEADQUARTERS, ARMY ENGINEER REGIMENT

WASHINGTON, D. C.

1. NAME OF THE PROPERTY: _____

2. LOCATION: _____

3. DATE OF DAMAGE: _____

4. TYPE OF DAMAGE: _____

5. AMOUNT OF DAMAGE: _____

6. REPAIRS REQUIRED: _____

7. COMMENTS: _____

03779

CERTIFICATE OF DEATH

03775

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN lb <u>47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>3900 Cathedral Ave n.w.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELODA B. DEAN</u>		4. DATE OF DEATH Month Day Year <u>MAR. 3 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1899</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EZRA DEAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET Golden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MONA BROWNLEE</u>		Address <u>3900 Cath. Ave. NW WASH, DC.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CEREBRO VASCULAR DISEASE</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>66</u> to <u>3 MARCH</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>2 MARCH</u> 19 <u>67</u> , and that death occurred at <u>10³⁰ P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Booth</u>		22b. DATE SIGNED <u>3 MAR 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. BOOTH MD</u>		22d. ADDRESS <u>2309 SHOREFIELD RD WHEATON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAR. 7 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bucklin Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bucklin MO.</u>
24. FUNERAL DIRECTOR <u>Joseph GAWLER SONS</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

0375

RECORD OF DEATH

0375

7

138

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03780

03776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Edward Dean</u>		4. DATE OF DEATH <u>3-29</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-87</u> 19 <u>79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Dean</u>		14. MOTHER'S MAIDEN NAME <u>Emma Goodwin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>377-12-3113</u>	
17. INFORMANT <u>Mary Dean</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO (b) <u>PROSTATIC HYPERTROPHY</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>6 YR</u> <u>AGE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>66</u> , to <u>MARCH</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>67</u> , and that death occurred at <u>4:14</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEO J DUNOVAN MD</u>		22d. ADDRESS <u>6218 WISC. AVE BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

03776

03776

03781

CERTIFICATE OF DEATH

03777

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>809 South Veitch Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Kindred</u> Last <u>De Loatche</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 October 1961</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry K. De Loatche, Jr.</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Giordano</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Granulocytopenia</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Thrombocytopenia</u>							
19. INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>40</u> (this hospital) attended the deceased from <u>Feb. 21</u> , 19 <u>67</u> , to <u>March 16</u> , 19 <u>67</u> , that <u>40</u> (we) lost saw the deceased alive on <u>March 16</u> , 19 <u>67</u> , and that death occurred at <u>7:40 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Herbert E. Kann, Jr., M.D.</u>				22b. DATE SIGNED <u>16 March 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Herbert E. Kann, Jr., M.D.</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				22e. REC'D BY REGISTRAR <u>20 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beechwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Boykins, Virginia</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Company</u>				25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03581

0333

2004

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03782

03778

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Ground Rd. PO Box 76</u>		d. STREET ADDRESS <u>White Ground Rd. PO Box 76</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>T.</u> Last <u>Diggins</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Cafored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1881</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Twyman</u>		14. MOTHER'S MAIDEN NAME <u>Julia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Bell</u>		M.D.	
EXAMINER'S NAME (Type)		22. DATE SIGNED <u>3/7/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Boyd's</u> <u>D/8</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville MD</u>	
25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03778

3782

Hardy Thomas

John

Colonel In-Service House
Cordia Vascular Disease

X

John A. Lee

X X

11/11

MAR 1 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23b Film #0387 3/30/67 ps

03783

CERTIFICATE OF DEATH

03779

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Falls Church			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 50 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 3020 Kadala Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle J. Last DONNELLY				4. DATE OF DEATH Month March Day 20 Year 1967			
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Feb. 1908	
9. AGE (In years last birthday) yrs. 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James Leonard JETER			
14. MOTHER'S MAIDEN NAME Mary Steele				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Falls Church Address Va. Mr. Daniel J. Donnelly, 3020 Kadala Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 20 , 19 67 , to Mar. 20 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 20 , 19 67 , and that death occurred at 450AM , from causes and on the date stated above.							
22a. SIGNATURE Peter T. Kirchner				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 21 Mar. 1967	
22c. PHYSICIAN'S NAME (Type) Peter T. Kirchner, M.D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Pearson's Funeral Home ADDRESS 472 North Washington St., Falls Church, Va.				25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

0372

3783

Virginia

Montgomery

Walla Church

70 min

eternity (trial)

3000 Kadena Place

Naval Hospital

March

January

Nov

22

22 Jan. 1908

Cave

Female

USA

West Virginia

Monmouth

Wally Steele

James Lehard

Walla Church

Va.

Mr. Daniel J. D. Smith, 3000 Kadena Place

Acute Myocardial Infarction

x

Mar. 20

Mar. 20

Mar. 20

of

Mar. 20

x

21 Mar. 1907

Naval Hospital, Bethesda, Md.

Peter T. Kitchner, M.D.

Washington, Va.

Washington National

Hotel

Person's Personal H. Co.

412 North Washington St., Walla Church, Va.

FOR STATE
HEALTH DEPT

03784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03780

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10413 Montrose Ave. apt. 102</u>			d. STREET ADDRESS <u>10413 Montrose Ave apt 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>B.</u> Last <u>DOUGLAS</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1967</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 12, 1900</u>		9. AGE (In years lost birthdays) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Department Store-Asst Mgr. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Adolph Augustus Axinroth</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Riley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-28-7560</u>		17. INFORMANT <u>Son</u> <u>Peter Douglas</u> <u>2625-N.E. 17th Ter. Ft. Lauderdale, Fla.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>157X</u> IMMEDIATE CAUSE (a) <u>Adenocarcinoma pancreas with widespread metastases</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>JOHN G. BALL</u>		22. DATE SIGNED <u>3/23/67</u> <u>Bethesda, Md.</u>	
EXAMINER'S NAME (Type)		22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03780

03781

March 22 1942
1415 Mountain Ave. Apt. 2
Patricia
Montgomery
Montgomery

March 22 1942
1415 Mountain Ave. Apt. 2
Patricia
Montgomery
Montgomery

March 22 1942
1415 Mountain Ave. Apt. 2
Patricia
Montgomery
Montgomery

03785

CERTIFICATE OF DEATH

03781

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington - D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u> d. STREET ADDRESS <u>2800 - Ontario Rd. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>E</u> Last <u>Doyle</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22 - 1882</u> 9. AGE (in years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>
13. FATHER'S NAME <u>Peter Roedl</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Langfried</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Address <u>Mary Joan Doyle same as #2</u>	
16. SOCIAL SECURITY NO. <u>578-60-4562</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Chronic Brain Syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Nice P. Campbell</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>		22d. ADDRESS <u>1629 Columbia Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Stotone & Co</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03781

03781

CERTIFICATE OF DEATH

Washington, D.C.

Kathleen Graham Manning

Died at home of

Kathleen Graham Manning

Washington, D.C.

Peter Reed

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Kathleen Graham Manning

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03786

CERTIFICATE OF DEATH

03782

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb DOA xxxx	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1	
d. STREET ADDRESS 755 Silver Spring Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruby Middle M Last Duvall		4. DATE OF DEATH Month 3 Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/00
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66	IF UNDER 24 HRS. Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Wade Macgruder		14. MOTHER'S MAIDEN NAME Ida Macgruder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Clarence F. Duvall, Sr. Address 755 Silver Spring Ave Husband same address as Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. (c) RHEUMATIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RHEUMATIC HEART DISEASE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 56 to March , 19 67 that (I) (we) last saw the deceased alive on 3-28 19 67 , and that death occurred at 8AM , from causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 3-29-67	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIV. BLVD E, SIL. SP., MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR Thomas E. Pumphrey, Inc.		25. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

\$2550

42580

03787

CERTIFICATE OF DEATH

03783

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14716 New Hampshire Ave.		d. STREET ADDRESS 14716 New Hampshire Ave.	
3. NAME OF DECEASED (Type or print) First Erma Middle Ethel Last Dwyer		4. DATE OF DEATH Month 3 Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/90
9. AGE (In years lost birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius Leizear		14. MOTHER'S MAIDEN NAME Elizabeth Bryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 214-03-9766	
17. INFORMANT William Dwyer Hospital Silver Spring, Maryland		Address 14716 N. H. Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO ISCHEMIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO ARTERIOSELEPTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2-3 WKS YES YES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION: OLD MYOCARDIAL INFARCT			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from August , 19 66 , to March 13 , 19 67 , that (I) (we) last saw the deceased alive on March 13 , 19 67 , and that death occurred at 4p M, from causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 14 Mar 67	
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis		22d. ADDRESS Medical Center, Olney, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery		23d. LOCATION (City or Town) (County) (State) Colesville, Maryland	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR MAR 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08783

03781

distension: old hemorrhoid
After 2000 cc. of
ischemic threat
operative threat
Failure 2-3

14 March
4/1
August 21

Robert F. Jones

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03788

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03784

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS 11805 Greenleaf Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry Middle Eisenberg Last Eisenberg			4. DATE OF DEATH Month March Day 13 Year 19 67		
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 August 1910	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY MEDICAL		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Louis Eisenberg			14. MOTHER'S MAIDEN NAME Mary Kapitza		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Catherine M. Eisenberg 11805 Greenleaf Ave. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cardio Vascular Disease DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 2 hr. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. Mar 13 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Naval Hospital Bethesda Montgomery Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3/13/67	
EXAMINER'S NAME (Type) John G. Ball M.D. Montgomery Co		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-16-1967		23c. NAME OF CEMETERY OR CREMATORY Alexandria National Cemetery Alexandria, Va.	
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin St., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

02561

03789

CERTIFICATE OF DEATH

03785

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home		d. STREET ADDRESS 10602 Woodsdale Drive	
3. NAME OF DECEASED (Type or print) First Mae Middle Eppley Last Eppley		4. DATE OF DEATH Month March Day 28 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theodore Gunnet		14. MOTHER'S MAIDEN NAME Annie Cosgrove	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Rev. Ann Sanderfer (same as above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 20 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 29, 19 61 , to March 28, 19 67 , that (I) (we) last saw the deceased alive on March 27, 19 67 , and that death occurred at 7:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Arthur S. Bresler		22b. DATE SIGNED 3-28-67	
22c. PHYSICIAN'S NAME (Type) Arthur S. Bresler		22d. ADDRESS 10881 Lockwood Drive Silver Spg. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 31, 19 67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR The S. H. Hines Co		ADDRESS Washington, DC	
25a. REC'D BY REGISTRAR MAR 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

03790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03786

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 4929 Blaine St,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harden Middle Hubert Last Evans				4. DATE OF DEATH Month Mar. Day 13 Year 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1912	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Orangeburg, S.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM EVANS				14. MOTHER'S MAIDEN NAME NEATHER Livingston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy Evans Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of heart due to puncture with DUE TO 982X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) sharp, pointed, instrumentality, probably DUE TO a knife. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Deceased stabbed in chest and abdomen with a sharp instrument.					
20c. TIME OF INJURY Month, Day, Year Hour 10:00 p.m. 3-12 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Norbeck Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/17/67		23c. NAME OF CEMETERY OR CREMATORY Alexandria National		23d. LOCATION (City or Town) (County) (State) ALEXANDRIA, VA	
24. FUNERAL DIRECTOR Brown + Diamond F.H. Inc.				25a. REC'D BY REGISTRAR DATE MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #14 Film #G386 3/13/67 pc

03791

CERTIFICATE OF DEATH

03787

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>20 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>1711 Cody Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Evans</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> Never married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	8. DATE OF BIRTH <u>August 10, 1901</u>		9. AGE (In years last birthday) yrs. <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Market Center</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baskerville, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Wesley Evans</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Margaret C. Newman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-3155</u>		17. INFORMANT <u>Margaret C. Evans</u> Address <u>1711 Cody Drive Silver Spring, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1967</u> , to <u>Mar 5, 1967</u> , that (I) (we) lost the deceased alive on <u>Mar 5, 1967</u> , and that death occurred at <u>8:30 P.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>Edward J. Richards</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-6-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>				22d. ADDRESS <u>10110 Georgia Avenue, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25. RECEIVED BY REGISTRAR <u>MAR 8 1967</u>			
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03792		03788	
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, include date of admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 45 days		d. STREET ADDRESS 9900 gardiner AVE,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EFFIE ELNORA EVELAND		4. DATE OF DEATH 3 Month 24 Day 19 Year 67	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-75
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSW		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos HESS		14. MOTHER'S MAIDEN NAME MARTHA HESS (same)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY ARTERY DISEASE (b) 3 hours (c) Years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic pyelonephritis, Pneumonia, Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 7, 1967 to Mar 24, 1967 , that (I) (we) lost the deceased alive on Mar 24, 1967 , and that death occurred at 8:52 PM , from causes on and on the date stated above.			
22a. SIGNATURE John L Ford		22b. DATE SIGNED MAR 24 1967	
22c. PHYSICIAN'S NAME (Type) JOHN L. FORD MD		22d. ADDRESS 531 UNIVERSITY BLVD E SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/1967	23c. NAME OF CEMETERY OR CREMATORY St James Cemetery	23d. LOCATION (City or Town) (County) (State) Fishing Creek Township, Penna
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW. 4.C		25a. REC'D BY REGISTRAR D MAR 28 1967	
		25b. REGISTRAR'S SIGNATURE John Charles Judge	

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3 MEDICAL CERTIFICATION

03785

MONT GOMERY

TRONA PARK

WASHINGTON SAN. & HOSPITAL 1900 GARDNER AVE.

AVE.

EFFIE ELLORA EVELAND

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7-5-12

X

FE WH

Hand

THOMAS HESS

Penmanship

MARTHA HESS (nee)

Hospital Records

USA

03788

MARYLAND

TRONA PARK

WASHINGTON SAN. & HOSPITAL 1900 GARDNER AVE.

AVE.

EFFIE ELLORA EVELAND

3

7-5-12

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Hand

THOMAS HESS

Penmanship

MARTHA HESS (nee)

Hospital Records

USA

03793

CERTIFICATE OF DEATH

03789

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Silver Spring			c. LENGTH OF STAY IN 1b 1 1/2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 8313 Flower Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Evangeline Ewy				4. DATE OF DEATH Month Day Year Mar 28 1967			
5. SEX Female		6. COLOR OR RACE Caus.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/5/1884	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) New Ulm, Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher				10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (County & State, or foreign country) New Ulm, Minnesota	
13. FATHER'S NAME Jorgen Benjamin Johnson				14. MOTHER'S MAIDEN NAME Anna Roland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-34-7092		17. INFORMANT Constance Ewy-Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Pseudotuberculous Polycystic Degeneration of the brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) arteriosclerosis DUE TO arteriosclerosis (c) cause of arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis Parkinsonism							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15 , 19 67 , to 3/28 , 19 67 ; that (I) (we) lost saw the deceased alive on 3/24 , 19 67 , and that death occurred at 9:10 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Charles W. Wolohan, M.D.				22b. DATE SIGNED 3-28-67			
22c. PHYSICIAN'S NAME (Type) Charles Wolohan, M.D.				22d. ADDRESS 831 University Blvd., E., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03789

CERTIFICATE OF DEATH

03789

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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CERTIFICATE OF DEATH

03790

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>7773 Emerson Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>FAASEN</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/05</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Air Force</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN FAASEN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>164-07-1093</u>		17. INFORMANT <u>MARY FAASEN</u> Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4801 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>post-operative idiosyncratic allergic reaction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5pm</u> , 19 <u>67</u> , to <u>21pm</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>30pm</u> 19 <u>67</u> , and that death occurred at <u>3:10 AM</u> , from causes and on the date stated above.							
22a. PHYSICIAN'S SIGNATURE <u>Joseph F. Schanno</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. SCHANNO</u> M.D.				22d. ADDRESS <u>928 9th Ave Beth. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-24-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort LINCOLN CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers & Riverdale, Md</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03520

0350

FOR STATE
HEALTH DEPT

03795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03791

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TOWN <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3004 Findley St. Road</u>				d. STREET ADDRESS <u>3004 Findley St. Road</u>		15-1	
3. NAME OF DECEASED (Type or print) <u>Charles Thomas Farrell</u>				4. DATE OF DEATH <u>3</u> Month <u>17</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-13-23</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>19</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Hurd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>216-16-996544</u>		17. INFORMANT <u>William F. Farrell</u> Address <u>3004 Findley Road Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to obstruction of pharynx</u> <u>922.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>with blood from nasal fracture</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, an epileptic, fell, fractured nose and hemorrhaged</u>					
20c. TIME OF INJURY Month, Day, Year <u>0:00</u> <u>3-17</u> <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <u>3/17/1967</u>
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (City, county or town) _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) <u>Silver Spring</u> (County) _____ (State) <u>Maryland</u>				
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>434 West Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>AR 22 1967</u>	25b. REGISTRAR SIGNATURE <u>John B. Thomas</u>		

10730

10730

The 20th

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03796

CERTIFICATE OF DEATH

03792

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>9 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> <u>15-1</u>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CHEVY CHASE NURSING AND CONValesCENT CENTER 5524 SOUTHWICK ST.</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>W.</u> Last <u>FAUNCE</u>			4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 NOVEMBER 86</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Map-Mounter-Photographer, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>PHILIP Pote Faunce</u>		
14. MOTHER'S MAIDEN NAME <u>Alice Carroll</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT Wife <u>Mary Walter Faunce</u> Address <u>Same as Item 2.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>coronary atherosclerosis</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Emphysema</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u> </u> to <u>1967</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>19 Jan</u> 19 <u>66</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>SEAN J. DAUM</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEAN J. DAUM</u>		22d. ADDRESS <u>1977 BATTERY LANE BETHESDA</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>		24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			
25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

02750

32560

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03797

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03793

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 21 HRS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN & HOSP.		d. STREET ADDRESS 7501 FLOWER AVE	
3. NAME OF DECEASED (Type or print) MR. PAUL		4. DATE OF DEATH Month 3 Day 18 Year 1967	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/06	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10b. KIND OF BUSINESS OR INDUSTRY CAB DRIVER	
11. BIRTHPLACE (State or foreign country) OKLAHOMA		12. CITIZEN OF WHAT COUNTRY? AMER.	
13. FATHER'S NAME ISSAC FEEBACK		14. MOTHER'S MAIDEN NAME KITURA WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) MARINES 3rd		16. SOCIAL SECURITY NO. 215-26-0267	
17. INFORMANT PT Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intracerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Interval between onset and death 22 hr.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 3/8/67	
EXAMINER'S NAME (Type) JOHN G. BALL		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Walter Waters		25a. REGD BY REGISTRAR DATE MAR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03798				CERTIFICATE OF DEATH				03794			
1. PLACE OF DEATH e. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE NEW JERSEY b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGEFIELD PARK			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENSINGTON NURSING HOME						d. STREET ADDRESS 18 CEDAR STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RACHAEL First Middle Last						4. DATE OF DEATH March 15 1967 Month Day Year					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1878		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MORRIS KLUGER						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER Address MRS. EDNA MAURER -3000 39th St., NW					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD (c) SCINILITH										INTERVAL BETWEEN ONSET AND DEATH instant yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DECUBITUS ULCERS - PNEUMONIA										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1967 , to 15 March 1967 , that (I) (we) last saw the deceased alive on 11 March 1967 , and that death occurred at 2:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Horace W. Bernton M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) HORACE W. BERNTON, M.D.						22d. ADDRESS 4743 BRADLEY BLVD., CHEVY CHASE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-17-67		23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY		23d. LOCATION (City, town or county) FAIRVIEW, NEW JERSEY		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY AND SONS WASHINGTON DC						ADDRESS		25a. REC'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

08798

CERTIFICATE OF DEATH

08798

NEW JERSEY

MONTGOMERY

RICHMOND PARK

KITTING

18 CHINA STREET

KINGSTON, URSING HALL

1878

X

THOMAS WHITE

RUSSIA

HOUSEWIFE

BRONX

MORRIS KIDGER

NEW YORK - 3000 30th St., NY

NY

2000 30th St., NY

2000 30th St., NY

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2000 30th St., NY

2000 30th St., NY

03799

CERTIFICATE OF DEATH

03795

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>24 hrs. 40 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5909 - Holland Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Albert M. Fick</u>		4. DATE OF DEATH <u>March 2 19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN HARVESTER</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>707-14-7297A</u>	
17. INFORMANT <u>Mrs. Nadine Schwarz - daughter- same #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs -</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>67</u> , to <u>3-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-2</u> , 19 <u>67</u> , and that death occurred at <u>3:10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>3-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shady Brooke-Lutheran</u>	23d. LOCATION (City or Town) (County) (State) <u>Shady Brook, Kansas</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03792

2256

03800

CERTIFICATE OF DEATH

03796

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> h. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>4817 Creek Shore Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>L.</u> Last <u>Fisher</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>3/11/1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Henry Van Hagen</u>		14. MOTHER'S MAIDEN NAME <u>Ella Eliz. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-56-7848</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion (acute)</u> <u>4201</u> DUE TO (b) <u>Coronary artery sclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 months</u> <u>10+ years</u> <u>20+ years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1966</u> , to <u>March 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1967</u> , and that death occurred at <u>8:05 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>R. Stephen Hulburt</u>		22b. DATE SIGNED <u>March 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. STEPHEN HULBURT</u>		22d. ADDRESS <u>3000 Dent Place, N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Langley</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09526

00220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03801				Items #5, 6 & 7				03797			
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Montgomery						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Manor Health Care Center						d. STREET ADDRESS 4611 - 27th St.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last Richard B. Forrest Sr.						Month Day Year March 27 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/1899		9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Atlantic Coast RR.				11. BIRTHPLACE (County & State, or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James L. Forrest						14. MOTHER'S MAIDEN NAME Mary M. Carrie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI		17. INFORMANT Address Mrs. Alice Forrest (above address) (Wife)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of R foot 260X DUE TO Arteriosclerotic disease of legs. (b) DUE TO Diabetes Mellitus (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Congestive Heart Failure										INTERVAL BETWEEN ONSET AND DEATH 2 wks. 5 years 10 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967 , to March 27, 1967 , that (I) (we) last saw the deceased alive on 3/27 19 67 , and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Samuel Dessoff						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/27/67			
22c. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF						22d. ADDRESS 1302-18th N.W. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 3/29/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.						ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR MAR 30 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

03801

03793

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
OFFICE OF THE CHIEF OF BUREAU
PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
WASHINGTON, D. C.
OFFICE OF THE CHIEF OF BUREAU
PLANT INDUSTRY
WASHINGTON, D. C.

03802

CERTIFICATE OF DEATH

03798

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
Cleared & Dep Medical Examiner 3/30/67

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross		e. STREET ADDRESS 1220 EAST WEST HWY.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMALIA		4. DATE OF DEATH Month 3 Day 30 Year 1967		5. AGE (In years last birthday) 79 yrs.	
6. SEX F	7. COLOR OR RACE W	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 10-10-87	10. IF UNDER 1 YEAR Months 3 Days 30 Hours 19 Min.	11. IF UNDER 24 HRS. Months 3 Days 30 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY AUSTRIA-HUNGARY		12. CITIZEN OF WHAT COUNTRY? ITALY	
13. FATHER'S NAME FRANK ADRARIO		14. MOTHER'S MAIDEN NAME CATHERINE POLCICH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 260X		17. INFORMANT DANIEL FRAGNUL		Address SAME AS #3	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO DIABETES MELLITUS (IN PART) (c) INDEFINITE					INTERVAL BETWEEN ONSET AND DEATH 1 DAY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 67 , to 3/30 , 19 67 , that (I) (we) last saw the deceased alive on 3/30 , 19 67 , and that death occurred at 3:45 A.M. from causes and on the date stated above.					
22a. SIGNATURE Lawrence D. Marcus		22b. DATE SIGNED 3/30/67		22c. PHYSICIAN'S NAME (Type) Lawrence D. Marcus, M.D.	
22d. ADDRESS 808 Pershing Dr., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-1-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or town) (County) (State) Silver Spring, Md.		
24. FUNERAL DIRECTOR COLLINS FUNERAL HOME		25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03738

03803

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03803					03799				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>			c. LENGTH OF STAY IN 1b <u>1 year 8 Mos.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Marylander Home of Rest, Inc.</u>					d. STREET ADDRESS <u>RFD #3, Box 349</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>MINNICH</u> Last <u>FRIDAY</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CHARLE, PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>FRANK MINNICH</u>					14. MOTHER'S MAIDEN NAME <u>KATHERINE BLOSER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-36-2891</u>		17. INFORMANT <u>Neice Edna F. Eader</u>		18. Address <u>2814 Linden Lane Silver Spring, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> <u>Bronchopneumonia, bilateral</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>15 years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>7/3</u> , 19 <u>65</u> , to <u>3/12</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>3/9</u> , 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>James P. Kerr</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/12/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>JAMES P. KERR M.D.</u>					22d. ADDRESS <u>DAMASCUS, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>3-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR <u>APR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		

03803

03803



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03804					03800						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						
Montgomery MARYLAND					Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b							
Takoma Park				47 Years							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
7108 Cedar Avenue					7108 Cedar Avenue				15-1		
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
ASENATH			SHELTON		FRYE		March 11,		19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		December 28, 1887		79 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife						Virginia			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Raleigh Shelton					Jane Limerick						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No					Mrs. Jane F. Morgan			# 2 above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute cardiac failure</i> 725X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>chronic arthritis</i> DUE TO (c) <i>Indefinite</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>July 7, 1965</i> to <i>Mar. 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>Mar. 11, 1967</i> , and that death occurred at <i>8:15 P.</i> M. from the causes and on the date stated above.											
22a. SIGNATURE <i>A. B. Little</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Mar. 11, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>A. B. LITTLE, M.D.</i>						22d. ADDRESS <i>6911 5th & New Wash. DC</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			3/ /1967		George Washington			Adelphi, Maryland			
24. FUNERAL DIRECTOR <i>J. Arthur Walter</i>						25a. REC'D BY REGISTRAR <i>Mar 15 1967</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			
254 Carroll Street, N.W. Washington, D. C. 20012											

03806

03800

Montgomery

Maryland

Montgomery

Takoma Park

47 Years

Takoma Park

1108 Cedar Avenue

1108 Cedar Avenue

ASSISTANT

SHERIFF

PRY

March 11

67

Female White

x

December 28, 1887

Housewife

Virginia

U.S.A.

Ralph Shellen

Jane Limerick

No

Mrs. Jane F. Norton

above

Initial

31 1967 George Washington

Annapolis, Maryland

Washington, D. C. 20012

CORONER NOTIFIED AND
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CLEARED BY MEDICAL EXAMINER - DR. BALL

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03805

CERTIFICATE OF DEATH

03801

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Essex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 59 Grandview Place	
3. NAME OF DECEASED (Type or print) First Laurence Middle U. Last Fullem		4. DATE OF DEATH Month March Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1898
9. AGE (In years lost birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired accountant		10b. KIND OF BUSINESS OR INDUSTRY Licht Architect	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) LEVINSON		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Moriarty Funeral Home		Address 76 Park St. Montclair, New Jersey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 MARCH 19 67 to 3 MARCH 19 67 , that (I) (we) last saw the deceased alive on 24 MARCH 19 67 , and that death occurred at 1:55 M, from causes and on the date stated above.			
22a. SIGNATURE Walter Goozh		22b. DATE SIGNED 3 March 67	
22c. PHYSICIAN'S NAME (Type) Walter Goozh, M.D.		22d. ADDRESS 2390 Glenmont Circle, Wheaton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF March 6, 1967	
23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cem. Upper Montclair, N. J.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Glen Carter		25a. REC'D BY REGISTRAR MAR 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03802

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY , Silver Spring, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland		c. LENGTH OF STAY IN lb 1 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 1220 Blair Mill Road	
3. NAME OF DECEASED (Type or print) First Middle Last Abe H Furr		4. DATE OF DEATH Month Day Year 3 30 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/00
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY GOV	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Azreal Furr		14. MOTHER'S MAIDEN NAME Rebecca Turkeniecz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918-19		16. SOCIAL SECURITY NO. 579-60-3166	
17. INFORMANT sister Mrs Rose Rogow		1220 Blair Mill Rd Silver Spring, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Balden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BALDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 3/30/1967		Address (Street, City, County or State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/31/67	23c. NAME OF CEMETERY OR CREMATORY Ohev Sholom-Talmud Torah Cem., Wash.D.C.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR APR 3 1967	
ADDRESS 3501-14th St.N.W.Wash.D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

03805

03806

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03807

03803

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Missouri Dist. of Col. b. COUNTY Missouri			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN lb 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield Washington 47-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 2801 Quebec St. NW. 960 S. Fremont St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte Emma GALBRAITH				4. DATE OF DEATH Month Day Year March 19 1967			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 18, 1914 52 yrs.	
9. AGE (In years last birthday) 52 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Toronto, Canada	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME John Fredic Kew Mens			
14. MOTHER'S MAIDEN NAME Fanny Georgina Thompson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 482-28-9858				17. INFORMANT Springfield, Mo. Address c/o Mrs. Charles Mr. Francis L. Galbraith 960 S. Fremont St., Gray			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with widespread metastases DUE TO (b) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 14, 1967 to March 19, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 19, 1967 , and that death occurred at 2:25A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Halbert C. Ashworth</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 19 March 1967	
22c. PHYSICIAN'S NAME (Type) H. E. Ashworth M. D.				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3-21-1967		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Toronto Canada	
24. FUNERAL DIRECTOR Joseph Gawler & Sons Inc.				25a. REC'D BY REGISTRAR DATE MAR 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

5130 Wisconsin Ave, N.W.
Washington, D. C.

03803

STATE OF DEATH

03804

Residence

Residence (City)

30 days

Residence (State)

Residence (County)

Residence (City)

Residence

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Residence

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John Francis Lawrence

John Francis Lawrence

100-28-0578

Residence of person with whom person was

February 14, 1967

March 19, 1967

March 19, 1967

Residence (City)

Residence (City)

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Residence

FOR STATE HEALTH DEPT.

03808

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03804

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN lb 22 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 68 Holy Cross Hospital				d. STREET ADDRESS RFD #2 Box 265		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Gallagher				4. DATE OF DEATH Month March Day 17 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 / 30 / 1900		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney-Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William J. Gallagher				14. MOTHER'S MAIDEN NAME Nano C. Bresnan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 578-44-1124		17. INFORMANT Margaret Ozburn Gallagher-same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple skull fractures with 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) intracranial hemorrhage due to fall DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased fell down stairway at home				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:30 P.M. 3-16 19 67			20d. INJURY OCCURRED 2 While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Gaithersburg Montg. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Leap M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) BELDEN R. LEAP, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, city, town or county) 3/17/1967				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Francis J. Collins				ADDRESS 3821-14th St. NW Wash DC		25a. REC'D BY REGISTRAR MAR 21 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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MAR 8 1981

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03809

CERTIFICATE OF DEATH

03805

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Pinellas</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN lb <u>36 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u> 118.3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>1725 66th Ave. North</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William James Gamble</u>				4. DATE OF DEATH Month Day Year <u>March 31 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1897</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gamble</u>				14. MOTHER'S MAIDEN NAME <u>Annie Wagner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>216-44-4485</u>		17. INFORMANT Address <u>Lelia Gamble - Wife - Same As #9</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of tail of pancreas with</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis to lungs, liver, adrenals and</u> DUE TO (c) <u>abdomen</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> , to <u>March 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 31, 1967</u> , and that death occurred at <u>5:45 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Aaron H. Traum</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>				22d. ADDRESS <u>827 Georgia Ave. Silver Spring Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Southlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Coshocton, Ohio</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>843 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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CERTIFICATE OF DEATH

03806

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 33 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 12650 Heming Lane	
3. NAME OF DECEASED (Type or print) First Katherine Middle Gibney Last GENTZEL		4. DATE OF DEATH Month March Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 10, 1925 9. AGE (In years last birthday) yrs. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Carbondale, Pennsylvania
13. FATHER'S NAME James Gibney		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Helen Coggins	
16. SOCIAL SECURITY NO.		17. INFORMANT Heming Lane Address Bowie, Md. Major Charles R. Gentzel, USAF, 12650	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse carcinomatosis secondary to intraductal carcinoma right breast DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } 170X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour :o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Feb. 11 , 19 67 , to Mar. 15 , 19 67 , that he (we) last saw the deceased alive on Mar. 15 , 19 67 , and that death occurred at 332A AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Francis D. Keenan, Jr.</i> M.D.		22b. DATE SIGNED 16 Mar. 1967	
22c. PHYSICIAN'S NAME (Type) Francis D. Keenan, Jr., M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 3/20/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR Nalley's Funeral Home 3200 Rhode Island Ave., Mt. Ranier, Md.		25a. REC'D BY REGISTRAR DATE MAR 21 1967 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03802

DEPARTMENT OF HEALTH

03802

History

Physical

Examination

33 days

Referral (initial)

1250 Herring Lane

Medical Department

General

History

Examination

Nov. 10, 1952

Case

Campbell, Pennsylvania

Referral

John Doe

James G. Doe

Living in

Doyle, Pa.

Major Charles E. Doe, USA, 1950

Referral certificate secondary to infectious
disease right breast

Pop. 11, 1951 Mar. 10, 1952

1952

Mar. 10, 1952

10 Mar. 1952

Dr. D. Doe, Jr., M.D., Naval Hospital, Bethesda, Md.

Washington

Washington Medical

1952

Referral

Referral to General Hospital

2000 Rhode Island Ave., N.E., Washington, D.C.

03811

CERTIFICATE OF DEATH

03807

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN lb 6 1/2 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE FLORIDA b. COUNTY WALTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DE FUNIAK SPRINGS d. STREET ADDRESS 48.3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Judge) Donald Stuart Gillis First Middle Last 4. DATE OF DEATH Month 3 Day 26 Year 19 67			
5. SEX Male	6. COLOR OR RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 11/5/1888 9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circuit Judge		10b. KIND OF BUSINESS OR INDUSTRY Law	11. BIRTHPLACE (County & State, or foreign country) Freeport, Florida
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dr. Angus M. Gillis	
14. MOTHER'S MAIDEN NAME Nancy McLean		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 261-78-0101A	
17. INFORMANT Mrs. Robt. Perry-Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of tongue			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 18, 1966 , to March 26, 1967 , that (I) (we) last saw the deceased alive on March 26, 1967 , and that death occurred at 4:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Raymond Bradshaw		22b. DATE SIGNED March 26, 1967	
22c. PHYSICIAN NAME (Type) Raymond Bradshaw, M.D.		22d. ADDRESS 345 University Blvd, West, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial	23b. DATE THEREOF Mar 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery	23d. LOCATION (City or Town) (County) (State) De Funiak Springs, Florida
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR MAR 29 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50260

11820

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03812

CERTIFICATE OF DEATH

03809

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>8504 16th STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle Last <u>GINS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/27/05</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISTRIBUTOR-MOTION PICTURES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENNETT GINSBERG</u>		14. MOTHER'S MAIDEN NAME <u>BRINDEL TROSHINSKY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>167 10 5391</u>	
17. INFORMANT <u>WIFE</u>		Address <u>MILDRED GINS - SEE d ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> , to <u>3/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>67</u> , and that death occurred at <u>1:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>3/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. LENNARD GOLD, M.D.</u>		22d. ADDRESS <u>8641 COLESVILLE RD., SIL.SPG.MD.</u>	
23a. BURIAL, CREMATION, EMPALEMENT (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSTVILLE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS WASHINGTON DC</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

VR A15 (4)
20 M 1/66

41260

1820

03813

CERTIFICATE OF DEATH

03810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Received by Dr. B. B. (M. W. 68)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>6304 Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>21 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. Ta'</u>		d. STREET ADDRESS <u>6301 W-Halbert Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Goldberg</u> Last <u>Goldberg</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Depty Asst Sec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Labor</u>	9. AGE (In years last birthday) yrs. <u>53</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>SAM Goldberg</u>		14. MOTHER'S MAIDEN NAME <u>Esther Berensohn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dr. Vera Goldberg - wife</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>260X</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>atherosclerosis</u> DUE TO (c) <u>Diabetic Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>67</u> , to <u>3-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-12</u> 19 <u>67</u> , and that death occurred at <u>12:35 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Ostrow</u>		22b. DATE SIGNED <u>3-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. OSTROW</u>		22d. ADDRESS <u>8107 EASTERN AVE S.S., MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gard.</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03810

CERTIFICATE OF DEATH

03810

DEATH RECORD

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03814

CERTIFICATE OF DEATH

03811

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>WASHER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joplin</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>			d. STREET ADDRESS <u>534 N. Moffet Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Goldstein</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-82</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ISADORE RINGOLSKY</u>				14. MOTHER'S MAIDEN NAME <u>HELEN ROSENFELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>490-32-9346</u>		17. INFORMANT <u>Admission Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 309X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Artery Disease, Acute Hepatitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>66</u> to <u>Mar 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 13</u> , 19 <u>67</u> , and that death occurred at <u>9 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Blaine H. Elg</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ELG</u>				22d. ADDRESS <u>8641 Colson Rd Silver Spring, Md</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Joplin, Mo.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217-9th St. N.W.</u>				25a. REC'D BY REGISTRAR <u>15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11850

STATE OF MICHIGAN

11850

RECEIVED
JAN 14 1964
MICHIGAN DEPARTMENT OF
NATURAL RESOURCES
DIVISION OF
WILDLIFE
AND
NATURAL
HISTORICAL
SITES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03815

03812

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>43 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>				d. STREET ADDRESS <u>8308 Flower Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Gooden</u>				4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-90</u>	9. AGE (In years lost birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Casket Co. Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer. U.S.A.</u>	
13. FATHER'S NAME <u>John Gooden</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Duff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>218-01-860</u>		17. INFORMANT <u>Elizabeth Gooden</u> Address <u>8308 Flower Ave Takoma Park, Md.</u> XXXXXXXXXXXXXXXXXXXX			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5371</u> <u>Pneumonia</u> DUE TO (b) <u>Bacterial infection</u> DUE TO (c) <u>Pulmonary emphysema - chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease - old MI; BPH</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-14-67</u> , 19 <u> </u> to <u>3-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>29 Mar</u> 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Kenneth B. Cruze</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Kenneth B. Cruze</u>				22d. ADDRESS <u>831 University Blvd. E., Silver Spring Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 31, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Thomas E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2180

51650

CERTIFICATE OF DEATH

03816

03313

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Far Rockaway, Long Island d. STREET ADDRESS 2287 Mott Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beatrice (None) Greene		4. DATE OF DEATH Month March Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 April 1914
9. AGE (In years lost birthday) yrs. 52		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph James		14. MOTHER'S MAIDEN NAME Ida Laden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. 062-30-8440	
17. INFORMANT The Medical Records		18. ADDRESS The Clinical Center, Bethesda, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Atheromatous Vascular Disease DUE TO (c) Type III Hyperlipoproteinemia		INTERVAL BETWEEN ONSET AND DEATH 24 hours 45 years 52 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 20 Feb. , 19 67 , to 7 March , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 March 1967 , and that death occurred at 10:00 , from causes on and on the date stated above.			
22a. SIGNATURE W. Virgil Brown		22b. DATE SIGNED 8 March 1967	
22c. PHYSICIAN'S NAME (Type) W. Virgil Brown, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 3-10-67	
23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		23d. LOCATION (City or Town) (County) (State) Elmont, L.I., N.Y.	
24. FUNERAL DIRECTOR Bernard Danzansky and Sons		25a. REC'D BY REGISTRAR MAR 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

61860

1550

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

03817

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03814

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Do A</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1		d. STREET ADDRESS <u>10266 Rview Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robin</u> First <u>Elaine</u> Middle <u>Greene</u> Last		4. DATE OF DEATH <u>March 16</u> Month <u>16</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25 1964</u>
9. AGE (In years lost birthday) yrs. <u>3 1/2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland - Mont.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Algie Greene</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Bolt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Matthew - Same as above</u>	
17. INFORMANT <u>Matthew - Same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X pneumonia Interstitial.</u> DUE TO (b) <u>12X</u> DUE TO (c) <u>12X</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>3/16/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-18-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cem. Vinton, Va.</u>		23d. LOCATION (City or Town) (County) (State) <u>Vinton, Virginia</u>	
24. FUNERAL DIRECTOR <u>Lutz Funeral Home</u>		25. REC'D BY REGISTRAR <u>11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03816

03816

Provenance: [illegible]

[illegible signature]

MAR 1 1961

CERTIFICATE OF DEATH

03818

03815

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN lb <u>15 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 UPTON STREET</u>		d. STREET ADDRESS <u>106 UPTON STREET</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH H. Griffith</u>		4. DATE OF DEATH <u>March 3</u> 19 <u>67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AARON B. HERSHBERGER</u>		14. MOTHER'S MAIDEN NAME <u>HESTER ANN WHIPP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. JOHN BACKUS</u>		Address <u>SAME AS ITEM #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> <u>Memoria</u> DUE TO (b) <u>Arteriosclerotic cardiovascular renal disease</u> DUE TO (c) <u>chronic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>67</u> , to <u>March 3</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>March 3</u> 19 <u>67</u> , and that death occurred at <u>5:00 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. A. Linthicum</u>		22b. DATE SIGNED <u>3/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. A. Linthicum, M.D.</u>		22d. ADDRESS <u>1105 Washington St. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MONOCACY CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BEALLSVILLE MONTG. M.D.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>BETHESDA MD.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 10 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03812

HOSPITAL OF DEATH

03812

MAR 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03819

CERTIFICATE OF DEATH

03316

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Dakota b. COUNTY 71-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 91 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgan			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Wayne Last Haagenson				4. DATE OF DEATH Month March Day 15 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 August 1962		9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days 15 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert I. C. Haagenson				14. MOTHER'S MAIDEN NAME Sandra Dixon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pneumonia undertermined etiology DUE TO (c) Acute lymphatic leukemia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 December, 1966 , to 15 March, 1967 , that 4 (we) last saw the deceased alive on 15 March 1967 , and that death occurred at 6:30 M. from causes on and on the date stated above.							
22a. SIGNATURE Herbert E. Kann, Jr., M.D.				22b. DATE SIGNED 16 March 1967		22c. PHYSICIAN'S NAME (Type) Herbert E. Kann, Jr., M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 3-18-67		23c. NAME OF CEMETERY OR CREMATORY Colgan Cemetery		23d. LOCATION (City or Town) (County) (State) Colgan, North Dakota	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR MAR 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03818

CERTIFICATE OF DEATH

03819

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03817

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle Loretta Last Hackley		4. DATE OF DEATH Month March Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY School Cafe.	9. AGE (In years last birthday) 71 yrs.
11. BIRTHPLACE (State or foreign country) Loudoun Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Greenwald		14. MOTHER'S MAIDEN NAME (Name) Mary Magdalene Mirley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-24-6031	
17. INFORMANT Son,		Address Howard Hackley 4216 Garrett Pk Rd. S.S., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency, Acute. DUE TO (b) Cardiovascular Disease - DUE TO (c) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 30 days Years -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John B. Ball		22. DATE SIGNED 3/7/67	
EXAMINER'S NAME (Type) John B. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/11/67	23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	23d. LOCATION (City or Town) (County) (State) Loudoun Hgts. Loudoun Va.
24. FUNERAL DIRECTOR Donald Eckley		25a. REC'D BY REGISTRAR MAR 13 1967	
ADDRESS Harpers Ferry, W.Va.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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A SOUTH EASTERN DISTRICT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #G387 4/6/67 pc

03821

CERTIFICATE OF DEATH

03818

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND/ N.Y. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS LeMarquis Hotel E-31st BROOKE GROVE FOUNDATION Street 49.3	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ELAM Last HACKMAN		4. DATE OF DEATH Month 3 Day 15 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-97
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEDICAL RECORDS DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 2 hypostatic DUE TO Paralytic Ileus Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) Electrolyte imbalance DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hr 2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pt hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 'p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/15 to 3/15 , 19 67 , and that death occurred at 1:35 PM , from causes and on the date stated above.			
22a. SIGNATURE C. H. LIGON, M. D.		22b. DATE SIGNED 3/15/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/17/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR MAR 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

03881

038818

PHOTOGRAPHY

CLINICAL

9 DAYS

CLINICAL

NORTHERN DEPT. HOSPITAL

WILKINSON

ELIZABETH

ELIZABETH

7-1-37

WHITE

WHITE

VIRGINIA

WHITE

MEDICAL RECORDS UNIT

10



RECEIVED CENTER, RANDY SPRING, N.C.

RECEIVED, N.C. DEPT. OF HEALTH

RECEIVED, N.C. DEPT. OF HEALTH

RECEIVED, N.C. DEPT. OF HEALTH

RECEIVED, N.C. DEPT. OF HEALTH

RECEIVED, N.C. DEPT. OF HEALTH

FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03822 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03319											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1605 BRISBANE ST</u>						d. STREET ADDRESS <u>1605 BRISBANE ST</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN</u> <u>Webster</u> <u>Hake</u>						4. DATE OF DEATH Month Day Year <u>3</u> - <u>12</u> - <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1882</u>		9. AGE (In years lost birthday) yrs. <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinetmaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W. Hake</u>						14. MOTHER'S MAIDEN NAME <u>Jane (Unknown)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>214-03-8875-A</u>		17. INFORMANT Address <u>Margaret Hake</u> <u>1605 Brisbane Street</u> <u>Silver Spring, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.						22. DATE SIGNED <u>3/13/1967</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>						DEPUTY MEDICAL EXAMINER <u>[Signature]</u> Address (Street, City or town, County)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Hyattsville, Md.</u>					
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>John B. Thomas</u> ADDRESS <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

03823

CERTIFICATE OF DEATH

03820

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 4 hrs 20 min			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 2115 Huffman Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First James Middle Robert Last HAMLETT		4. DATE OF DEATH Month March Day 2 Year 1967			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1940		9. AGE (In years lost birthday) 27 yrs.	IF UNDER 1 YEAR Months 2 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Greenville, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Lloyd Hamlett				14. MOTHER'S MAIDEN NAME Janie Louise Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) 1959-1967		16. SOCIAL SECURITY NO. 260 58 6719		17. INFORMANT Columbia Address S. C.		Mrs. Rosalyn A. Hamlett, 2115 Huffman Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic bronchial pneumonia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphoblastic leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 2, 1967 , to March 2, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 2, 1967 , and that death occurred at 1035 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>J. B. Emery, Jr.</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 3, 1967	
22c. PHYSICIAN'S NAME (Type) J. B. Emery, Jr., M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-1967		23c. NAME OF CEMETERY OR CREMATORY Newnan Cemetery		23d. LOCATION (City or Town) (County) (State) Newnan, Georgia	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W., Washington, D.C.				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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UNITED STATES OF AMERICA

THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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U.S. Army

Department of the Army

Office of the Secretary

Washington, D. C.

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U.S. Army

Department of the Army

Office of the Secretary

Washington, D. C.

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U.S. Army

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03824

CERTIFICATE OF DEATH

03821

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 15 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 4507 Highland Ave.	
3. NAME OF DECEASED (Type or print) First EMMA Middle M. Last HAMMERLI		4. DATE OF DEATH Month Mar. Day 19 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1875
9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? Switzerland.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-3920	
17. INFORMANT Son		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Left Coronary artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 HRS 10421
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 18 MAR , 19 67 , to 19 MAR , 19 67 , that (I) (we) last saw the deceased alive on 18 MARCH 19 67 , and that death occurred on 2 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 3-19-67	
22c. PHYSICIAN'S NAME (Type) RONALD W. BAAR, MD.		22d. ADDRESS 10401 OLD GEORGETOWN RD. BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-22-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 28 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONTINUED OF PAGE

Page 1

Page 2

Page 3

Page 4

Page 5

Page 6

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Page 10

Page 11

Page 12

Page 13

Page 14

Page 15

Page 16

Page 17

Page 18

Page 19

Page 20

Page 21

Page 22

03825

CERTIFICATE OF DEATH

03822

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8712 Rayburn Road		d. STREET ADDRESS 8712 Rayburn Road	
3. NAME OF DECEASED (Type or print) First Chai Middle Kon Last Han		4. DATE OF DEATH Month March Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1887 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Korea
13. FATHER'S NAME Chong Eung Lee		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Dr. Pum Suk Han - son - same item #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) years			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition and Electrolyte Imbalance due to Colitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 8 , 1967, to March 1 , 1967, that (I) (we) last saw the deceased alive on Feb 25 , 1967, and that death occurred at 11:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE George H. Mitchell		22b. DATE SIGNED March 2 67	
22c. PHYSICIAN'S NAME (Type) George H. Mitchell		22d. ADDRESS 11125 Rockville Pike, Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/4/67	23c. NAME OF CEMETERY OR CREMATORY Rockville	23d. LOCATION (City or Town) (County) (State) Rockville, Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAR 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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P. 321

03826

CERTIFICATE OF DEATH

03823

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4977 Battery Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4977 Battery Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jack First Middle Last Haney		4. DATE OF DEATH Month Day Year 3-28-1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-1912
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Office	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Wilbur Haney		14. MOTHER'S MAIDEN NAME Marie Simmons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 280-05-5969	
17. INFORMANT J. W. Peregoy, 7801 Fulbright Ct.		Address Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Carcinoma of left colon DUE TO (c) 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. - 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) (County) (State) -
21. I certify that (I) (this hospital) attended the deceased from 1955 to Mar 28, 1967 , that (I) (we) last saw the deceased alive on Mar 27, 1967 , and that death occurred at 2:15 PM , from causes on and on the date stated above.			
22a. SIGNATURE Thomas F. McMahon		22b. DATE SIGNED APR 3 1967	
22c. PHYSICIAN'S NAME (Type) Thomas F. McMahon M.D.		22d. ADDRESS 3000 Penn. Ave. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4-1-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5150 Wisc. Ave. N.W. Wash. DC.		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03858

MINUTE OF MEETING

03858

MEMORANDUM

FOR THE RECORD

DATE

1957

MEMORANDUM

FOR THE RECORD

DATE

MEMORANDUM

FOR THE RECORD

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MEMORANDUM

FOR THE RECORD

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FOR THE RECORD

03827

CERTIFICATE OF DEATH

03824

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie, Maryland 15-1 20175</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>12824 Holiday Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>Louise</u> Last <u>Hanlon</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19</u> <u>MARCH</u> , 19 <u>67</u>	9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>18</u> Min <u>28</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gerald V. Hanlon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mary Maloney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <u>Gerald V. Hanlon-father-same item #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7715</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Respiratory distress syndrome, prematurity</u> DUE TO (c) <u>asphyxia of ? etiology</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 19, 1967</u> , to <u>Mar 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 21, 1967</u> , and that death occurred at <u>11:57</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Morris Fintel</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS FINTEL MD</u>				22d. ADDRESS <u>704 Gorman Ave Laurel Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Jan 3/23/67</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>1733 Rockville Pike</u>		23d. LOCATION (City or Town) (County) (State) <u>Chicago, Ill.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03851

RECEIVED

03851

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03828

CERTIFICATE OF DEATH

03825

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Waxahachie, Texas</u> b. COUNTY <u>Ellis</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waxahachie</u> 80-3	
c. LENGTH OF STAY IN 1b <u>9 years</u>		d. STREET ADDRESS <u>200 Overhill Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Nursing Home, Silver Spring, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Zephna J. HARDING</u>		4. DATE OF DEATH <u>MAR 3 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>98</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ellis Co. Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Trippet</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Beatrice Armstrong</u>		Address <u>9212 Columbia Blvd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 28</u> , 19 <u>67</u> , to <u>Mar 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 28</u> , 19 <u>67</u> , and that death occurred at <u>1:55</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R. Thibadeau</u>		22b. DATE SIGNED <u>Mar 2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>11,000 OLD GEORGETOWN ROAD ROCKVILLE, MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7 March 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waxahachie City Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Waxahachie, Ellis, Texas</u>
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u>		25a. REG'D BY REGISTRAR <u>MAR 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

0352-8660

4880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03823

CERTIFICATE OF DEATH

03826

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. "1" Germantown, d. STREET ADDRESS Box 112					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove				c. LENGTH OF STAY IN 1b 5 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Hargraves				4. DATE OF DEATH Month March Day 22 Year 1967					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1881			
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 35 Days 15		IF UNDER 24 HRS. Hours 15 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Magazine Publishing					
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Blackston Riley				14. MOTHER'S MAIDEN NAME Margaret Agnes Williams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. •					
17. INFORMANT Marguerite Appleby				Address Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1. Terminal Bronchopneumonia 2. Arteriosclerotic Cardio-vascular-renal Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No accident.								INTERVAL BETWEEN ONSET AND DEATH 2 weeks 15 years?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.								20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) Washington, D. C.	
20g. (County) Montgomery								20h. (State) Maryland	
21. I certify that (I) (the doctor) attended the deceased from August 1, 1965, to March 22, 1967, that (I) saw the deceased alive on March 22, 1967, and that death occurred at 12 noon, from the causes and on the date stated above.									
22a. SIGNATURE M. McKendree Boyer, M. D.								22b. DATE SIGNED March 24, 1967	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.								22d. ADDRESS 9701 Church Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-25-67		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			
23d. LOCATION (City, town or county) Washington, D. C.				(State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber								ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR MAR 29 1967								25b. REGISTRAR'S SIGNATURE Charles Judge	

03828

03828

Montgomery

Montgomery

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Rt. #1 Germantown,

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Cedar Grove

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March 22 67

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Aug. 21, 1981

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USA

Magazine Publishing Washington, D. C.

Clerk

Margaret James Williams

John Blackston Riley

Marguerite Ropley same as 25

No

1. Terminal Bronchopneumonia

2. Arteriosclerotic Cardio-vascular-renal Disease 13 years

No accident

March 22, 1967

March 22, 1967

March 22, 1967

9701 Quince Street

Washington, D. C.

Washington, D. C.

Unmanned Cemetery

3-21-67

Burial

Francis H. Barber Laytonville, Va.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03827

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital				d. STREET ADDRESS 7111 Popular Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myra Middle May Last Harman				4. DATE OF DEATH Month March Day 5 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-11-90	
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months 7 Days 11		11. IF UNDER 24 HRS. Hours 11 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Hulst				14. MOTHER'S MAIDEN NAME xx White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Cardio vascular disease							INTERVAL BETWEEN ONSET AND DEATH 2 weeks ? 2 weeks years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction of left cerebral hemisphere due to occlusion of left middle cerebral artery							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in hospital striking head on oxygen tank			
20c. TIME OF INJURY Month, Day, Year Hour o.m. to 4:30 xx 3 3 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Takoma Park Montg Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 3/7/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Prince Georges Co. Md.	
24. FUNERAL DIRECTOR Arthur Walters Washington D.C.				25. RECEIVED BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03831

03830

2 2/1/1

John D. Jones

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03831

CERTIFICATE OF DEATH

03828

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HONY CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 8519 Glenview Ave #303 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EMILY Ann NASSETT		4. DATE OF DEATH Month Day Year March 23 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE (In years last birthday) 53
11. BIRTHPLACE (County & State, or foreign country) Dunkirk, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Smoczynski		14. MOTHER'S MAIDEN NAME Julia Spekeczynski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 126-28-9816	
17. INFORMANT Francis Hassett		Address 8519 Glenview Avenue Takoma Park, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central nervous system Metastases 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1966 , to 3/23 1967 , that (I) (we) last saw the deceased alive on 3/23 1967 , and that death occurred at 7:54 A.M. from causes and on the date stated above.			
22a. SIGNATURE G. Lennard Gold		22b. DATE SIGNED 3/23/67	
22c. PHYSICIAN'S NAME (Type) G. Lennard Gold, M.D.		22d. ADDRESS 8641 Colesville Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial	23b. DATE THEREOF Mar 27, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Dunkirk, New York
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR MAR 27 1967	
ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03881

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date

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Quincy, New York

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

03832

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G387 3/30/67

CERTIFICATE OF DEATH

03829

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNIVERSITY NURSING HOME</u>		d. STREET ADDRESS <u>1807-9th ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>HAWKINS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894</u> <u>4-3-1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOTEL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CHARLES CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES ROBERT HAWKINS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA BARMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Unlabeled heart infarction</u> DUE TO <u>Obstruction of the</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u>Cumulative of the Prostate & Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Severe Rheumatoid Arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 15</u> , 19 <u>67</u> , to <u>Mar 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 22</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Russell C. Bufalino</u>		22b. DATE SIGNED <u>Mar 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino</u>		22d. ADDRESS <u>1129 University Blvd W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Ceme.</u>	23d. LOCATION (City or Town) (County) (State) <u>Maryland</u>
24. FUNERAL DIRECTOR <u>Stewart Funeral Home-4001 Benning Rd.,</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 28 1967</u>	

03830

REPUBLIC OF DENMARK

03830

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03833

CERTIFICATE OF DEATH

038330

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN lb 3 xdxhr	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			15-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 9607 Garwood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle Leonard Last Hayden				4. DATE OF DEATH Month 3 Day 27 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/07		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired policeman			10b. KIND OF BUSINESS OR INDUSTRY D.C. police Dept		11. BIRTHPLACE (County & State, or foreign country) Wayside, Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lynn Hayden				14. MOTHER'S MAIDEN NAME Mary Wise			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO None		16. SOCIAL SECURITY NO. 216-46-9386		17. INFORMANT Wife, Katherine Hayden Address 9607 Garwood St. S. S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January , 19 66 , to March 27 , 19 67 , that (I) (we) last saw the deceased alive on February 2 , 19 67 , and that death occurred at 1:50 M. from causes and on the date stated above.							
22a. SIGNATURE James M. Loftus				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 27, 1967	
22c. PHYSICIAN'S NAME (Type) James Loftus, M.D.				22d. ADDRESS 5451 Conn. Ave., N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.		
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc.				ADDRESS 434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR MAR 31 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

Cleared with Medical Examiner

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76850

6880

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03834

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03831

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Prince Williams			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel Lee Hedges				4. DATE OF DEATH March 26 19 67			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Dec 44	
9. AGE (In years lost birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Lee Hedges				14. MOTHER'S MAIDEN NAME Rosemarie Micheline Barriette			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes				16. SOCIAL SECURITY NO. 223 60 9378			
17. INFORMANT Paul L. Hedges				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration and contusion of brain DUE TO (b) Skull fracture DUE TO (c) Trauma from automobile accident INTERVAL BETWEEN ONSET AND DEATH 48 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 10:30 p.m. Mar. 24 19 67				20d. INJURY OCCURRED 3 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street				20f. (City or town) Prince William (County) Woodbridge (State) Va.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/67		23c. NAME OF CEMETERY OR CREMATORY Dumfries Cemetary		23d. LOCATION (City or Town) (County) (State) Dumfries, Prince Wm. Va.	
24. FUNERAL DIRECTOR W. W. Chambers Co., 1400 Chapin St. NW, Wash. D.C.				25a. REC'D BY REGISTRAR MAR 29 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03835

CERTIFICATE OF DEATH

03833

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Gainesville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN tb 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS RFD #1	
3. NAME OF DECEASED (Type or print) John F. HENRY, SR.		4. DATE OF DEATH Month March Day 22 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1899
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Manhattanville, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Joseph Henry		14. MOTHER'S MAIDEN NAME Margaret Nevins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 1, 2, Korean		16. SOCIAL SECURITY NO. 087 09 4765	
17. INFORMANT Mrs. Kathryn M. Henry, RFD #1, Gainesville		Address Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Carcinoma of the lung DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14, 1967 to March 22, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 22, 19 67 , and that death occurred at 355 PM , from causes and on the date stated above.			
22a. SIGNATURE Peter T. Kirchner M.D.		22b. DATE SIGNED March 23, 1967	
22c. PHYSICIAN'S NAME (Type) Peter T. Kirchner, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home 1500 West Braddock, Alexandria, Virginia		25a. REC'D BY REGISTRAR MAR 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03833

03833

Virginia

Montgomery

Galveston

10 days

Hobbs (rural)

1947

Naval Hospital

Henry, Ark. March 22, 1947

John

March 22, 1947

John

Manassas, New York

U. S. Marine Corps

Marines Moving

John Robert Henry

Virginia
Mr. Nathan K. Henry, 1231 1/2 Galveston

Mr. J. J. Nathan 1231 1/2 Galveston

Department of the Army

Department of the Army

March 22, 1947

March 22, 1947

March 22, 1947

March 22, 1947

Naval Hospital, Bethesda, Md.

Letter to Kinross, J. D.

Arlington, Virginia

Arlington National

Chief

Private - Mrs. J. Kinross, Home
1231 1/2 Galveston, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03836

CERTIFICATE OF DEATH

03834

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
c. LENGTH OF STAY IN 1b <u>24da</u>				15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. + HOSP.</u>				d. STREET ADDRESS <u>7108 MAPLE AVE.</u>			
3. NAME OF DECEASED (Type or print) <u>FRANCISCO (NONE) HERNANDEZ</u>				4. DATE OF DEATH <u>March 9-1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/15/07</u>	
9. AGE (In years <u>59</u> mos. <u>1</u> birth day) yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u> Hours <u>1</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAR TENDER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CUBA</u>				12. CITIZEN OF WHAT COUNTRY? <u>CUBA</u>			
13. FATHER'S NAME <u>FRANCISCO HERNANDEZ</u>				14. MOTHER'S MAIDEN NAME <u>CARMAN MONTILLA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital RECORDS</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tumor right hypopharynx and right neck area</u> DUE TO <u>239X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>239X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Since Oct 67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary emphysema</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>Feb 14</u> , 1967, to <u>March 9</u> , 1967, that <u>he</u> (we) last saw the deceased alive on <u>March 9</u> , 1967, and that death occurred at <u>7:00</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Aaron H. Traum</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 10 '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				22d. ADDRESS <u>5237 Georgia Ave Silver Spring Maryland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>March 13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>J. Robert Waters</u>				25a. REC'D BY REGISTRAR <u>254 Cotton St. W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>MAR 13 1967</u>			

15260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 11 and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CASE DISCUSSED WITH CO. H.E. and C. E. H. P.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03837

CERTIFICATE OF DEATH

03835

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY New York		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 1 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City 69-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15505 Good Hope Rd.			d. STREET ADDRESS YWCA-		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Haddie Grace Hernandez			4. DATE OF DEATH Month 3 Day 3 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/15/01		9. AGE (In years lost birthday) yrs. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Psychiatric Nurse		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penn.	
13. FATHER'S NAME George Hernandez			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			14. MOTHER'S MAIDEN NAME Haddie K. Thorman		
16. SOCIAL SECURITY NO. 042 26 0149			17. INFORMANT Dorothy Fisk, Sister, Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO ISCHEMIC HEART DISEASE DUE TO ARTERIO-SCLEROTIC C.V. DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Sudden Yrs. Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS - HYPERTENSION - ANGINA PECTORIS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from OCTOBER, 1966 to MARCH 3, 1967 , that (1) (we) just saw the deceased alive on FEB 27 1967 , and that death occurred at 5:30 P M, from causes and on the date stated above.					
22a. SIGNATURE Donald R. Lewis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MARCH 3, 67	
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis		22d. ADDRESS Medical Center, Olney, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 6 1967	23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville Md.		25a. REC'D BY REGISTRAR MAR 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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March 6 1967 Tavonaville

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W. J. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

03838

03838

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>3113-LEE STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Hiley</u>		4. DATE OF DEATH Month <u>3</u> Day <u>-</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charlie Blalock</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Ferguson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Walter M. Hiley - 13111 Evanston ST.</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 CARDIAC FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>3 YRS</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 15</u> , 19 <u>66</u> , to <u>MARCH 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 29</u> , 19 <u>67</u> , and that death occurred at <u>12:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. O'Connor</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u>		22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-3-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>5130 Wisc. Ave. N.W., Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03839

CERTIFICATE OF DEATH

03837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>16902 Oak Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Ernest Hill</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-08</u>	
9. AGE (In years last birthday) yrs. <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Richard Hill</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Mitchel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A. (coronary artery insufficiency)</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002.2</u> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - Pulmonary tuberculosis (active)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>Feb 26</u> , 1967, to <u>March 4</u> , 1967, that (H) (we) last saw the deceased alive on <u>March 4</u> , 1967, and that death occurred at <u>8:16 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Alvin H. Trautman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alvin H. Trautman</u>				22d. ADDRESS <u>8137 Georgia Ave - Silver Spring, Maryland, 20910</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandy Springs, Md</u>	
24. FUNERAL DIRECTOR <u>Robert C. Snowden</u>				25a. REC'D BY REGISTRAR <u>Rockville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03333

RECEIVED BY MAIL

03333

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03840 Item #20 & d cilm #4300 3/10/67 03838											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 3 months, 3 days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fairland Nursing Home				d. STREET ADDRESS 2101 Thirdland Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Hnatysh Last Hnatysh				4. DATE OF DEATH Month 3 - Day 2 - Year 1967							
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-17-90		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Carpentry				11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME - - - - -				14. MOTHER'S MAIDEN NAME - - - - -							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - - - -				16. SOCIAL SECURITY NO. 092-09-5290				17. INFORMANT Walter Hnatysh			
				Address Kensington, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 4 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 66 , to 3/2 , 19 67 , that (I) (we) last saw the deceased alive on 3/1 , 19 67 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Raymond T. Benack MD								22b. DATE SIGNED 3/2/67			
22c. PHYSICIAN'S NAME (Type) Raymond T. Benack MD								22d. ADDRESS 4115 Colie Drive, Wheaton Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 3-4-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Md.			
24. FUNERAL DIRECTOR JOSEPH CAWLER'S Sons Inc								25. REGISTRAR'S SIGNATURE Charles Judge			
ADDRESS 4115 Colie Drive, Wheaton Md.								DATE MAR 6 1967			

Monmouth

Silver 2-1-17

fairland street house

John

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Make W

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Carpenter

Carpenter of Austria

11-2-11

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03841

CERTIFICATE OF DEATH

03839

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakoma Park City		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 11 Leighton Place, S.S. Md 20901	
3. NAME OF DECEASED (Type or print) First ROBERT Middle CLYDE Last HOGAN		4. DATE OF DEATH Month March Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/25
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prin Pol / D.C. Public Serv		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLYDE HOGAN		14. MOTHER'S MAIDEN NAME HELEN HUSSEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 579-20-9992	
17. INFORMANT Mrs. Helen Hogan		Address 11 Leighton Place Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT (RECURRENT) DUE TO 442X (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO over 2 years. (c) RENAL-VASCULAR DISEASE (suspected) DUE TO over 2 years.		INTERVAL BETWEEN ONSET AND DEATH over 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February 10, 19 67 , to March 2, 19 67 , that (I) (we) last saw the deceased alive on March 2, 19 67 , and that death occurred at 1150P M. from causes on and on the date stated above.			
22a. SIGNATURE Hugo G. Graziani M.D.		22b. DATE SIGNED March 3, 1967.	
22c. PHYSICIAN'S NAME (Type) HUGO G GRAZIANI, M.D.		22d. ADDRESS 10101 GEORGIA AVE, S.S. MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF March 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE MAR 8 1967	
ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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03833

CERTIFICATE OF DEATH

03833

Name: Robert [unclear]
 Sex: Male
 Date of Birth: 5/22/22
 Place of Birth: [unclear]
 Date of Death: 5/22/22
 Place of Death: [unclear]
 Cause of Death: [unclear]
 Physician: [unclear]
 Hospital: [unclear]

Hypertensive Cardiovascular Disease
 (Hypertension)

Cause of Death: Hypertensive Cardiovascular Disease
 Date of Death: 5/22/22
 Place of Death: [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03842

CERTIFICATE OF DEATH

03840

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PG. MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. & HOSP.</u>		e. STREET ADDRESS <u>2103 GUIFORD Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>VIRGINIA ELIZABETH HOLLAND</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>74</u>
11. BIRTHPLACE (County & State, or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS LOVEL</u>		14. MOTHER'S MAIDEN NAME <u>SARAH QUARMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unusual Pneumonia</u> DUE TO (b) <u>C.V.A.</u> DUE TO (c) <u>Hypertensive A.S.H.D.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>3/4</u> , to <u>3/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>67</u> , and that death occurred at <u>6:50</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>7105 - RIGGS RD., HYATTSVILLE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee FUNERAL Home 3004th St. N.E. Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

03700

03880

1001 01/11/11

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03843

CERTIFICATE OF DEATH

03841

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
c. LENGTH OF STAY IN lb <u>March 31</u>		d. STREET ADDRESS <u>13320 Dauphine St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Health Care Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA KATHERINE HORN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1899</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>GEORGE WHITE</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE RAAB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>213-14-8148</u>	
17. INFORMANT <u>MRS. MARGARET K. MURPHY</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ectopic gestation - Secto int.</u> DUE TO (b) <u>Cervicovaginitis</u> DUE TO (c) <u>Primary Ca - Rectal</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1967</u> to <u>March 15, 1967</u> that (I) (we) last saw the deceased alive on <u>Mar 14, 1967</u> , and that death occurred at <u>10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>3/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU, MD</u>		22d. ADDRESS <u>ROCKVILLE, MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/20/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>
24. FUNERAL DIRECTOR <u>Carlton Funeral Home, Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

19250

63820

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03844

CERTIFICATE OF DEATH

03842

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 78 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shenandoah Junction		25-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014				d. STREET ADDRESS (No street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Francis David Housden		4. DATE OF DEATH Month Day Year March 17 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 16 July 1951		9. AGE (In years last birthday) yrs. 15	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus M. Housden			14. MOTHER'S MAIDEN NAME Elsie P. Hite				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO (b) Bronchiectasis DUE TO (c) Cystic Fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } 2893						INTERVAL BETWEEN ONSET AND DEATH 2 weeks Greater than 1 year Since birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 December, 1966 , to 17 March, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 March 1967 , and that death occurred at 12:02 A.M. from causes on the date stated above.							
22a. SIGNATURE Georges Peter				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 17 March 1967	
22c. PHYSICIAN'S NAME (Type) Georges Peter, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-20-67		23c. NAME OF CEMETERY OR CREMATORY Edge Hill		23d. LOCATION (City or Town) (County) (State) Charles Town W. Va	
24. FUNERAL DIRECTOR Fitzsim 389 R.I. on nw. Wash. & D.C.				25a. REC'D BY REGISTRAR DATE MAR 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03884

03884

03884

Name		Address		City		State		Zip	
John Doe		123 Main St		New York		NY		10001	
Age		Sex		Race		Religion		Marital Status	
35		Male		Caucasian		Protestant		Married	
Education		Occupation		Income		Assets		Liabilities	
High School		Teacher		\$15,000		\$50,000		\$10,000	
Health		Mental		Physical		Social		Family	
Good		Stable		Excellent		Active		Happy	
Hobbies		Interests		Skills		Languages		Travel	
Reading		Golfing		Cooking		Spanish		Europe	
References		Comments		Signature		Date		Initials	
John Smith		Very Good		[Signature]		10/1/73		JD	

Vertical text on the right margin, possibly a file number or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03845

CERTIFICATE OF DEATH

03843

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belted</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steen Spring</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>4508 Bennett Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Synn</u> First Middle Last <u>Howard</u>		4. DATE OF DEATH <u>March 22</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/1895</u> 12 yrs.
9. AGE (In years last birthday) <u>72</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELEVATOR OPER.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Howard</u>		14. MOTHER'S MAIDEN NAME <u>Martha W. Hutton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-14-8576</u>	
17. INFORMANT <u>Stewart Margaret McCormick</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericarditis and myocarditis, viral</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1967</u> , to <u>March 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1967</u> , and that death occurred at <u>150 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u>		22b. DATE SIGNED <u>March 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Tr. Geo Co. MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1400 CHAPIN ST N.W. D.C.</u>		DATE <u>MAR 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03846		Item #2d Film #386 3/20/67 pc				03844			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital					d. STREET ADDRESS 8505 Springdale Rd.				
3. NAME OF DECEASED (Type or print) First Middle Last Randolph Howard					4. DATE OF DEATH Month Day Year March 5 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12.1883		9. AGE (In years last birthday) 83 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive				10b. KIND OF BUSINESS OR INDUSTRY Society Foreign		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Howard					14. MOTHER'S MAIDEN NAME Martha Regan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 579-44-1906		17. INFORMANT Son - Paul C. Howard		Address 5001 Brookdale Rt. (?) Washington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 20016 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Bronchopneumonia, Cerebral hemorrhage DUE TO (c) Bunch pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958, to March 5, 1967, that (I) (we) last saw the deceased alive on April 4 1967, and that death occurred at 3:45 a.m. from the causes and on the date stated above.									
22a. SIGNATURE George Hays				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-7-67		22c. PHYSICIAN'S NAME (Type) 10400 Conn. Ave. Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Cremation 13-7-67		13-7-67		LEB'S CREMATORY		WASHINGTON D.C.			
24. FUNERAL DIRECTOR LEB FUNERAL HOME 3004 STN				ADDRESS		25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

03880

03880

1961-1962

COPIES

1961-1962

1961-1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03847

CERTIFICATE OF DEATH

03845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2531 Glenallen Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last 4. DATE OF DEATH <u>3/11/67</u> Month Day Year 19		5. SEX <u>M</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3/11/67</u> 9. AGE (In years last birthday) yrs. <u>6</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Jimmy C. Humphreys</u> 14. MOTHER'S MAIDEN NAME <u>Linda Fahr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>172-32-9400</u> 17. INFORMANT <u>Father</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary resorption atelectasis</u> DUE TO (b) <u>due to prematurity</u> DUE TO (c) <u>7625</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Subarachnoid hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>67</u> , to <u>3/11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>67</u> , and that death occurred at <u>11:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>Melvin W. Sandmyer</u>		22b. DATE SIGNED <u>3/11/67</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1106 Spring St. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>14 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

7-221160

03842

13280

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03846

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS --		15-1	
3. NAME OF DECEASED (Type or print) James Thomas Hungerford				4. DATE OF DEATH Month 3 Day 10 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/19/06		9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if seasonal) Lumberman Saw Mill			10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William C. Hungerford				14. MOTHER'S MAIDEN NAME Lillian Pedicord			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 230-32-5532		17. INFORMANT Address William C. Hungerford, Father, Germantown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency Acute. DUE TO (b) Cardio Vascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 72 hr. Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3/11/67	
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY Upper Seneca	
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR MAR 15 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			
				25d. LOCATION (City or Town) (County) (State) Cedar Grove, Mont. Md.			

02388

02388

Sam Hill

500-35-2235

John D. Hall

Upper areas

Cedar Grove, Mont. La.

Francis H. Carter Laytonville, Mo.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

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(I)

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03849

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonville</u>		c. LENGTH OF STAY IN lb <u>15 M.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. Fawcett's office</u>				d. STREET ADDRESS <u>R. Fd # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Imes</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>67</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16 1912</u> 54 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Imes</u>				14. MOTHER'S MAIDEN NAME <u>Bertie Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4301</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) <u>Cardio Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				22. DATE SIGNED <u>3/16/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Warren Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Martinsburg Montg Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03883

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03850

CERTIFICATE OF DEATH

ADOLPH IRONS 03848

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> Home MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>mond.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>	
c. LENGTH OF STAY IN 1b <i>12 days</i>		d. STREET ADDRESS <i>7600 Carroll Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Adolph</i> First Middle Last <i>Irons</i>		4. DATE OF DEATH Month <i>3</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-12-90</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months <i>24</i> Days <i>24</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Frank L. Irons</i>		14. MOTHER'S MAIDEN NAME <i>Eellie Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Nursing Home Records</i>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i> DUE TO (b) <i>Metastatic Carcinoma</i> DUE TO (c) <i>Carcinoma of prostate</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr +</i> <i>2 yrs +</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>3-12</i> , 19 <i>67</i> , to <i>3-24</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-22</i> , 19 <i>67</i> , and that death occurred at <i>6:30</i> AM, from causes and on the date stated above.		
22a. SIGNATURE <i>R. H. Sandstrom</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>3-24-67</i>
22c. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom M.D.</i>	22d. ADDRESS <i>7701 Carroll Ave. Takoma Park, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	23b. DATE THEREOF <i>March 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Asbarnville Cemetery</i>
23d. LOCATION (City or Town) (County) (State) <i>Asbarnville, Brick Township, N.J.</i>		
24. FUNERAL DIRECTOR <i>William Waters Washington, D.C. 20012</i>		25a. REC'D BY REGISTRAR DATE <i>27 1967</i>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03830

34850

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY in lb - <u>15 1/2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16804 Oak Hill Rd.</u>				e. STREET ADDRESS <u>16804 Oak Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>S.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12 1916</u>	
9. AGE (In years lost birthday) <u>50</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaning</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas Jackson</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Wife - Emma Jackson</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Cardio Vascular Disease</u> DUE TO (c) <u>4201</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/9/67</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Round Oak Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Spencerville Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Swarden</u>				25a. REC'D BY REGISTRAR <u>Mar 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	
ADDRESS <u>Roxville, Md.</u>							

03881

03881

MEDICAL EXAM BY CHIEF OF BUREAU

UNITED STATES DEPARTMENT OF AGRICULTURE

Department of Agriculture

Washington

March 1914

1834 Cor. 1st St.
1834 Cor. 1st St.

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1834 Cor. 1st St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03852

CERTIFICATE OF DEATH

03850

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> 151 d. STREET ADDRESS <u>7710 Brookville Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucy Ellen Jacobsen</u>		4. DATE OF DEATH Month Day Year <u>March 11 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-98</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Coral Michigan - Montclair - USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Stewart Newell</u>		14. MOTHER'S MAIDEN NAME <u>Silworthorne, Ellen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-54-3546</u>	
17. INFORMANT <u>Hugh Jacobsen, son.</u>		18. ADDRESS <u>2735 P St. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Rupture</u> DUE TO (c) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>50 min</u> <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1953</u> to <u>3/11 1967</u> , that (I) (we) last saw the deceased alive on <u>3/11 1967</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frank Y. Jagers Jr</u>		22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK Y. JAGGERS JR.</u>		22d. ADDRESS <u>5707 WISCONSIN AVE WCh Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE, MD.</u>
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS,</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>	
ADDRESS <u>5130 WIS. AVE. N.W. WASH., D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03820

03820

MAR 1 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03853

CERTIFICATE OF DEATH

03851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Box 103</u>	
3. NAME OF DECEASED (Type or print) <u>Louis Leo Jones</u>		4. DATE OF DEATH <u>March 10 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/84</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Jones</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Clay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-05-5185A</u>	
17. INFORMANT <u>Estelle King</u>		Address <u>996 - W. Mont. Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several months</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia and pulmonary infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>March 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 10</u> 19 <u>67</u> , and that death occurred at <u>5:15</u> p.m., from causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u>		22b. DATE SIGNED <u>March 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. Mitchell, M.D.</u>		22d. ADDRESS <u>11125 Rockville Pike, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Providence Meth.</u>		23d. LOCATION (City or Town) (County) (State) <u>Kempton, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	

03851

CERTIFICATE OF DEATH

03853

Name of Deceased		Date of Death	
John Doe		1957	
Age		Sex	
55		Male	
Cause of Death		Place of Death	
Heart Disease		Home	
Time of Death		Signature of Physician	
10:00 AM		[Signature]	
Signature of Registrar		Official Seal	
[Signature]		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03854

CERTIFICATE OF DEATH

03853

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Saint Hosp</u>				d. STREET ADDRESS <u>2009 Blue Ridge Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eleanor VMN Kallinsky</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-12</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 21 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical Clerk Dept of Agric</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Manheim</u>				14. MOTHER'S MAIDEN NAME <u>Mayme Markowitz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>074-05-9904</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>5 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, OBESITY</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 1961, to <u>MARCH 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>MARCH 22</u> , 1967, and that death occurred at <u>4:32 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>MARCH 21 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert L. KRICHMAR</u>				22d. ADDRESS <u>7733 MASA AVENUE N.W. WASHINGTON DC 20012</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM PARK</u>		23d. LOCATION (City or town) (County) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR <u>Seashy Funeral Home</u> ADDRESS <u>4217 9th</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

03854

CERTIFICATE OF DEATH

03853

Interpreted

Dr

EXHIBIT 3/2/07 DATA MEMPHIS FALLS CHURCH VA
MEMPHIS FALLS CHURCH VA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

03855

CERTIFICATE OF DEATH

03854

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Convalescent Home</u>			d. STREET ADDRESS <u>400 Springbrook Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>(J. Hanson)</u> Last <u>Kane</u>			4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1877</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ithica, New York</u>	
13. FATHER'S NAME <u>Unknown Payne</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Elmer C. Kane</u> Address <u>400 Springbrook Drive Silver Spring, Maryland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>15 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>66</u> , to <u>3/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> , from causes on and on the date stated above.					
22a. SIGNATURE <u>M. B. Queen</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/26/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		22d. ADDRESS <u>44 Univ. Blvd. W. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colesville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03824

MINISTRY OF HEALTH

03824

11



Cleared by Dr. John Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03856		CERTIFICATE OF DEATH		03855	
1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital			d. STREET ADDRESS 8201 16th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Benjamin			4. DATE OF DEATH Month March Day 1 Year 19 67		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/22/88		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Abraham Kay		
14. MOTHER'S MAIDEN NAME Ida			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1917-18		
16. SOCIAL SECURITY NO. 579 42 9179			17. INFORMANT Son, Marvin Kay Address Home address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Arterio-sclerosis DUE TO 10 yrs (c) Ess. Benign Hypertension DUE TO 16 years					INTERVAL BETWEEN ONSET AND DEATH 10 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1952 , to 3-1, 1967 , that (I) (was) lost saw the deceased alive on 3-1, 1967 , and that death occurred at 830 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Leroy Robins		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-1-67	
22c. PHYSICIAN'S NAME (Type) LEROY ROBINS		22d. ADDRESS 2480-16th St. N.W. Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/3/67		23c. NAME OF CEMETERY OR CREMATORY Ohev Shalom-Talmud Torah	
23d. LOCATION (City or Town) (County) (State) Washington, D.C.		24. FUNERAL DIRECTOR Bernard Danzansky & Sons St. N.W. Wash. D.C.			
25a. REC'D BY REGISTRAR 6		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE 1967	

22860

2080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03857

CERTIFICATE OF DEATH

03856

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS RFD 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Turner Middle J Last Keith		4. DATE OF DEATH Month 3 Day 22 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/85
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman		10b. KIND OF BUSINESS OR INDUSTRY Nursery	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Keith		14. MOTHER'S MAIDEN NAME Margaret Andrew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-4243	
17. INFORMANT Hospital Records, Olney, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarct, anterior DUE TO (c) Arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/2 , 19 67 to 3/22 , 19 67 , that (I) two times saw the deceased alive on 3/22 , 19 67 , and that death occurred at 7:20 P M, from causes and on the date stated above.			
22a. SIGNATURE James P. Kerr , M.D.		22b. DATE SIGNED 3/23/67	
22c. PHYSICIAN'S NAME (Type) James P. Kerr M.D.		22d. ADDRESS 26618 Ridge Rd., Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/67	
23c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		23d. LOCATION (City or Town) (County) (State) Browningsville, Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

03825

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03858

CERTIFICATE OF DEATH

03857

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL				d. STREET ADDRESS 306 HALSEY ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL ROBERT KELLY				4. DATE OF DEATH Month MARCH Day 1 Year 1967			
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 AUG 53	9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT C. KELLY				14. MOTHER'S MAIDEN NAME PATRICIA MC CORMICK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT 306 HALSEY ROAD, ANNAPOLIS, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal shutdown DUE TO Acute lymphoblastic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemorrhagic diathesis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 27 , 19 67 , to Mar. 1 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 1 19 67 , and that death occurred at 211A M , from causes and on the date stated above.							
22a. SIGNATURE <i>D. R. Foreman</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 March 1967	
22c. PHYSICIAN'S NAME (Type) D. R. Foreman, M.D.				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 3/3/1967		23c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS, ANNE ARUNDEL, MD.	
24. FUNERAL DIRECTOR John M. Taylor, 147-149 Gloucester St., ANNAPOLIS, MD.				25a. REC'D BY REGISTRAR MAR 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03854

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03859

CERTIFICATE OF DEATH

03858

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 6 Wesley Court	
3. NAME OF DECEASED (Type or print) Mattie C. Kemp		4. DATE OF DEATH Mar. 31 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-86
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Curtis		14. MOTHER'S MAIDEN NAME Harriet Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Montgomery Gen. Hospital		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Intracranial Hemorrhage DUE TO (b) Arteriosclerosis - Gen. stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Pneumonia - Bronchial ② A.H.D.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-18, 1967 to 3-31, 1967 , that (I) (we) last saw the deceased alive on 3-30 1967 , and that death occurred at 6:30 am from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 3-31-67	
22c. PHYSICIAN'S NAME (Typed) Dr. Jack Schumacher		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-3-67	23c. NAME OF CEMETERY OR CREMATORY Laytonsville	23d. LOCATION (City or Town) (County) (State) Laytonsville, Mont. Md.
24. FUNERAL DIRECTOR Francis H. Barber Funeral Home Laytonsville Md.		25a. REC'D BY REGISTRAR APR 4 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

03828

03828

UNITED STATES OF AMERICA

Washington, D.C.

Washington, D.C.

Washington, D.C.

1-3-57

Page 1

Charles A. Smith, President of the Board of Directors

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03860

CERTIFICATE OF DEATH

03859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>5350 Edgeman Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>INEZ</u> Middle <u>B.</u> Last <u>KIRBY</u>				8. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-82</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Lin</u>				14. MOTHER'S MAIDEN NAME <u>Susan Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Husband</u> <u>Paul L. Kirby</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses multiple and</u> DUE TO <u>Left femoral artery thrombosis with</u> (b) <u>gangrene left leg</u> DUE TO <u>Arteriosclerosis, general, very severe</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>72 hours</u> <u>5 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility, very advanced due to arteriosclerosis 7 yrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>3-7-1967</u> , that (I) (we) last saw the deceased alive on <u>3-6-1967</u> , and that death occurred at <u>2:30 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase 15 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Michaels, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03880

CONTINUATION OF DEATH

03880

MAY 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03861

CERTIFICATE OF DEATH

03860

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 72 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS Route 3, Box 206		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Alexander KLINE				4. DATE OF DEATH Month March Day 20 Year 1967			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 November 1945	
9. AGE (In years last birthday) yrs. 21		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. 21	
11. BIRTHPLACE (County & State, or foreign country) Locaconing, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Titus Leroy Kline				14. MOTHER'S MAIDEN NAME Jean Caldwell Spier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO.		17. INFORMANT Rawlings Address Maryland Mr. Titus L. Kline, Route 3, Box 206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 178X IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Embryonal carcinoma of testes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Jan. 7 , 19 67 , to March 20 , 19 67 , that he (we) lost saw the deceased alive on March 20 , 19 67 , and that death occurred at 4:00 P.M. from causes on and on the date stated above.							
22a. SIGNATURE Lawrence A. Jones				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 21, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence A. Jones, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/24/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N. W., Washington, D.C.				25. REC'D BY REGISTRAR DATE 23 1967		26. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

03880

03881

Identifying

Referral (initial)

Naval Hospital

Thomas

Male

U. S. Marine Corps

Titus Henry Kline

yes

Unidentified

Unidentified

Mr. Titus H. Kline, House 3, Box 200
New York

San Francisco, Calif.

San Francisco, Calif.

13 November 1941

Alexander Kline

Kline

San Francisco

72 days

House 3, Box 200

San Francisco

03862

CERTIFICATE OF DEATH

03861

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 47 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
3. NAME OF DECEASED (Type or print) First William Middle Marvin Last Kniep		4. DATE OF DEATH Month March Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 November 1931
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry William Kniep		14. MOTHER'S MAIDEN NAME Laura Hook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 13 January, 1967 , to 1 March, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 March 1967 , and that death occurred at 1:50 M. from causes and on the date stated above.			
22a. SIGNATURE Martin H. Cohen		22b. DATE SIGNED 1 March 1967	
22c. PHYSICIAN'S NAME (Type) Martin H. Cohen, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-3-67	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Cem.	23d. LOCATION (City or Town) (County) (State) Red Hill, Penna.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25. REC'D. BY REGISTRAR MAR 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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Cleared - Med. Exam. by Dr. Shapiro

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>22 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>11368 Cherry Hill Road #304</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Soren</u> Middle <u>Thomas</u> Last <u>Koontz</u>			4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1967</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 20, 1965</u> 9. AGE (In years last birthday) <u>2 1 yrs.</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas W. Koontz</u>					14. MOTHER'S MAIDEN NAME <u>Phyllis Hart</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mc Comb Funeral Home</u>		Address <u>1140 Lake Avenue, Fort Wayne, Indiana</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 492X DUE TO <u>Bacterial infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>60 hrs.</u> DUE TO (c) <u>36 hrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3/23, 1967</u>, to <u>3/24, 1967</u>, that (I) (we) last saw the deceased alive on <u>3/23, 1967</u>, and that death occurred at <u>PM</u>, from the causes and on the date stated above.									
22a. SIGNATURE <u>Melvin Shapiro</u>					22b. DATE SIGNED <u>3/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Melvin Shapiro, M.D.</u>		
22d. ADDRESS <u>1040 University Blvd. W., Silver Spring, Md.</u>					22e. REC'D BY REGISTRAR <u>Charles Judge</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>			23b. DATE THEREOF <u>Mar 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Fort Wayne, Indiana</u>		
24. FUNERAL DIRECTOR <u>John B. Thompson</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles E. Coleman - John Paul MD.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
03864		03863	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.	
c. LENGTH OF STAY IN 1b 1 Yr. 3 mths.		d. STREET ADDRESS 6036 Rossmore Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RESMOR SANITARIUM & HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fern Kost		4. DATE OF DEATH Month March Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 July 1895
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ford Overstreet		14. MOTHER'S MAIDEN NAME Isabelle Hillard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis H201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic vascular disease DUE TO (c) Chronic pulmonary emphysema			INTERVAL BETWEEN ONSET AND DEATH 5 mins
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from Sept. , 1964, to March , 1967, that (1) (we) last saw the deceased alive on Jun 31 , 1967, and that death occurred at 9:00 AM , from causes and on the date stated above.			
22a. SIGNATURE James R. Coleman MD		22b. DATE SIGNED 3/7/67	
22c. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN MD		22d. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-8-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Roselawn Mem. Park		23d. LOCATION (City or Town) (County) (State) Springfield Illinois.	
24. FUNERAL DIRECTOR HARTON FUNERAL HOME		25a. REC'D BY REGISTRAR MAR 15 1967	
ADDRESS 4748 Wisc. Ave. N.W.		25b. REGISTRAR'S SIGNATURE Charles J. J. J.	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03865

CERTIFICATE OF DEATH

03864

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 107 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 121 U Street, N.W.	
3. NAME OF DECEASED (Type or print) Charlotte Hicks LAGUERTA		4. DATE OF DEATH Month MARCH Day 9 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1896
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillip Hicks		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579 54 0633	
17. INFORMANT N.W., Washington Address D.C. Mrs. Emma Ford Washington, 402 Shepherd St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1750 Carcinoma Ovaries IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 22 , 19 66 , to Mar. 9 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 9 , 19 67 , and that death occurred at 330AM , from causes and on the date stated above.			
22a. SIGNATURE R. J. Kinney		22b. DATE SIGNED March 9, 1967	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-13-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Jarvis Funeral Home ADDRESS 1432 U St., N.W., Washington, D. C.		25a. REC'D BY REGISTRAR DATE Mar 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03866

03865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>24h.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9818 Cahrell Terrace.</u>				d. STREET ADDRESS <u>9704 Armistead Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First Middle Last				4. DATE OF DEATH <u>March 5</u> 19 <u>67</u> Month Day Year			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hw.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Anne Roach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Daughter Katherine Dougherty.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> stating the underlying cause last. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				22. DATE SIGNED <u>3/5/67</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>MAR. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>		23d. LOCATION (City or Town) (County) (State) <u>Newton</u> <u>M.H.S.S.</u>	
24. FUNERAL DIRECTOR <u>W. J. Altman</u> <u>3603 14th St NW</u> <u>LY 2411</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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2007-2-24

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT

03867

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San. & Hospital</i>		d. STREET ADDRESS <i>13505 Turkey Branch</i>	
3. NAME OF DECEASED (Type or print) <i>Raymond Elsworth Lawson</i>		4. DATE OF DEATH Month <i>3</i> Day <i>23</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-27-17</i>
9. AGE (In years last birthday) yrs. <i>49</i>		10. IF UNDER 1 YEAR Months <i>15</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army Eng Corp</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Zachariah B. Lawson</i>		14. MOTHER'S MAIDEN NAME <i>Martha Hickson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-8527</i>	
17. INFORMANT <i>Item #2 Mrs Vivian Lawson (wife)</i>		18. ADDRESS <i>13505 Turkey Branch</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO (b) <i>Severe Coronary Artery Heart Disease</i> DUE TO (c) <i>Heart Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		22. DATE SIGNED <i>3/23/1967</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		23. DATE THEREOF <i>3/27/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>	
23c. LOCATION (City or Town) (County) (State) <i>Prince George County Md.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>MAR 27 1967</i>	
ADDRESS <i>1331 Rock. Pike Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

08308

08308

RECEIVED BY THE SECRETARY OF THE ARMY

[Faint, mostly illegible handwritten text, possibly a memorandum or report, covering the majority of the page.]

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03868

CERTIFICATE OF DEATH

03867

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Montana b. COUNTY Daniels			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scobey			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS Box 561		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gerald Middle Emanuel Last Lebel				4. DATE OF DEATH Month March Day 24 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11 July 1930		9. AGE (In years lost birthday) yrs. 36	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adlar Lebel				14. MOTHER'S MAIDEN NAME Lucy Girard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 Cardio-respiratory failure DUE TO (b) Liver failure DUE TO (c) Congestive heart failure						INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 months opost-operative open heart surgery(aortic & mitral valve/ replacement)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 14 March, 1967 to 24 March, 1967 , that (X) (we) last saw the deceased alive on 24 March, 1967 , and that death occurred at 8:00 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Hamner Hannah III				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 25 March 1967	
22c. PHYSICIAN'S NAME (Type) Hamner Hannah III, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/67		23c. NAME OF CEMETERY OR CREMATORY Scobey, Cemetery		23d. LOCATION (City or Town) (County) (State) Scobey, Montana	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR C. Glen Carter		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
2434 Georgia Ave. Sil. Spr. Md.				DATE MAR 29 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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0.84 7.5 0

CERTIFICATE OF DEATH

03868

03869

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN 1b 27 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 7706 13th Street N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harold Middle V. Last Lese		4. DATE OF DEATH Month March Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1907 September 10
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 10	IF UNDER 24 HRS. Hours 10 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law	11. BIRTHPLACE (County & State, or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel	
14. MOTHER'S MAIDEN NAME -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Peter Lese, son	
Address Greenbelt, Md.		6202 Breezewd. Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis (undifferentiated) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Primary Pulmonary Cancer DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH 10 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 17, 1967 , to March 16, 1967 , that (I) (we) last saw the deceased alive on March 16, 1967 , and that death occurred at 11:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen		22b. DATE SIGNED March 17, 1967	22c. PHYSICIAN'S NAME (Type) Dr. Gene Cohen
22d. ADDRESS 1106 Spring Street, S.S. Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/19/67	23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cem.	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR St. NW, Wash. DC	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03869

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE BRAGONIER LEWIS		4. DATE OF DEATH Month March Day 14 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1871
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Alfred C. Bragonier		14. MOTHER'S MAIDEN NAME Elizabeth Magee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-0289	
17. INFORMANT 5100 Dorset Ave. Virginia S. Arnold, Chevy Chase, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease. DUE TO (c) years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of Hip -			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in Nursing Home -	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1/29 1967 p.m. 1/29		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home -		20f. (City or town) (County) (State) Kensington Montgomery Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED March 15, 1967		Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-17-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03880

03880

2000

Cerebrovascular Disease
Cerebral Atherosclerosis

Fracture of H/W -

Fracture of H/W -

Fracture of H/W -

John A. Ball

03871

CERTIFICATE OF DEATH

03870

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6700 BROOKVILLE ROAD		d. STREET ADDRESS 6700 BROOKVILLE ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD W. LINDSAY		4. DATE OF DEATH Month Day Year MARCH 12, 19 67	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/08
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVESTIGATOR		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT	
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALTER N. LINDSAY		14. MOTHER'S MAIDEN NAME ISABEL V. DICKSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 270-12-4633	
17. INFORMANT JANICE M. LINDSAY, WIFE		Address SAME AS #2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Generalized DUE TO (b) Carcinoma Pancreas DUE TO (c) 3 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb-10, 1967 , to 3-12, 1967 , that (I) (we) last saw the deceased alive on 3-11, 1967 , and that death occurred at 4:45 AM , from causes on and on the date stated above.			
22a. SIGNATURE P.P. Andrews		22b. DATE SIGNED 3-12-67	
22c. PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D.		22d. ADDRESS Washington D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/14/67	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d. LOCATION (City or Town) (County) (State) ROCKVILLE, MD.
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC., WASHINGTON, D.C.		ADDRESS WASHINGTON, D.C.	
25. DEC'D BY REGISTRAR MAR 14 1967		REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03230

03230

INVESTIGATION

CHARTER

8730 BUCKINGHAM ROAD

CHARTER

CHARTER

CHARTER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #G387 4/7/67 ps

03872

CERTIFICATE OF DEATH

03871

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH OF STAY IN 1b Silver Spring, Md. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLT CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. d. STREET ADDRESS 8311 Navaho Dr. Silver Spring, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANNIE H. LITTMAN		4. DATE OF DEATH 3 Month 31 Day 19 Year 67	
5. SEX FEMALE		6. COLOR OR RACE CAUC	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/89	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nathan Horn	
14. MOTHER'S MAIDEN NAME Betsy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Bernard Littman, 3124 Brooklawn Terr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia (clinical) DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Renal cell carcinoma right kidney		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Mar 31, 1967 ; that (I) (we) last saw the deceased alive on Mar 31, 1967 , and that death occurred at 2:00 PM , from causes and on the date stated above.	
22a. SIGNATURE BLAINE H. GIG		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) BLAINE H. GIG		22d. ADDRESS 1641 Coleman Rd Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/2/67	
23c. NAME OF CEMETERY OR CREMATORY Adas Israel		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St., NW, Wash. DC		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE	

15250

SS85C

FOR STATE
HEALTH DEPT.

03873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03872

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9039 SLIGO CR. Phw.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9039 SLIGO CR. Phw.</u> e. IS RESIDENCE ON A FARM? <u>NO</u>	
3. NAME OF DECEASED (Type or print) <u>HAROLD CARL LOHREN</u> First Middle Last		4. DATE OF DEATH <u>3-16-1967</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-08</u> 9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOVT-SEC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>PHILA. PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK LOHREN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA LOHREN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Mrs. B.A. Lohren (Wife) Same as # 1</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary artery heart disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>3/16/1967</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town) (County) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, P.G., Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. SIGNED BY REGISTRAR <u>20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03875

03875

Information 3-11-57
Research Institute, Inc.
P.O. Box 100
New York, N.Y. 10001

03874

CERTIFICATE OF DEATH

03873

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL, SILVER SPRING				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 609 BROMLEY STREET							
3. NAME OF DECEASED (Type or print) First GEORGE Middle V. Last LUCKYJ				4. DATE OF DEATH Month 3 Day 26 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/28/27		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Department		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (County & State, or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Vasyl Luckyj				14. MOTHER'S MAIDEN NAME Marie Borovicka			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 571-44-4736		17. INFORMANT Zenia Luckyj, 2 a, b, c, d above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 Myocardial arrest IMMEDIATE CAUSE (a) Myocardial arrest DUE TO (b) Extensive myocardial infarct DUE TO (c) Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/23 , 19 67 , to 3/24 , 19 67 , that (I) (we) last saw the deceased alive on 10:15 AM 3/25 1967 , and that death occurred at M , from causes on and the date stated above.							
22a. SIGNATURE Richard P. Delaney				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY				22d. ADDRESS 4323 - HARVARD - SIL SPR. MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 30 MAR 67		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Charles J. Jones 7400 Keokuk Ave NW WASH DC				25a. REC'D BY REGISTRAR MAR 29 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT. M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03874											
1. PLACE OF DEATH COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN lb 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				15.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10210 Capitol View Avenue						d. STREET ADDRESS 10210 Capitol View Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Melanie			First Middle Last (nni) Lund			4. DATE OF DEATH Month Day Year March 21 19 67					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 5, 1966		9. AGE (In years last birthday) yrs. 3 Mon 5 Days 16		IF UNDER 1 YEAR Hours 3 Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jeffrey B. Lund						14. MOTHER'S MAIDEN NAME Melinda Middleton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Jeffrey B. Lund 10210 Capitol View Avenue Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral pneumonitis accompanied by asphyxia											
921.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) due to aspiration of gastric contents											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased infant vomited and aspirated gastric contents							
20c. TIME OF INJURY Hour e.m. 3:00 P.M.		Month, Day, Year 3-21 19 67		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Silver Spring		(County) (State) Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Read						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3/22/1967		
EXAMINER'S NAME (Type) BELDEN R. READ M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 4434 Georgia Avenue Prince Georges Co., Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar 23, 1967		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			22d. LOCATION (City, town, or country) (State) Prince Georges Co., Maryland		
23. FUNERAL DIRECTOR Name Glen Carter Address 4434 Georgia Avenue City Silver Spring, Md.											
24. REGISTRAR'S SIGNATURE Charles Judge DATE MAR 27 1967											

0307

STATE OF TEXAS, COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03876

CERTIFICATE OF DEATH

03875

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Silver Spring c. LENGTH OF STAY IN 1b 90 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lepard Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland New Jersey b. COUNTY Montgomery ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Basking Ridge d. STREET ADDRESS 49 Lyons Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luella Middle R. Last Lytle		4. DATE OF DEATH Month March Day 22 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1885
9. AGE (In years last birthday) 81 yrs.		10. FINDER 1 YEAR <input type="checkbox"/> FINDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household		11b. KIND OF BUSINESS OR INDUSTRY - - -	
12. BIRTHPLACE (County & State, or foreign country) Grove City, Penna.		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Charles Ruffing		15. MOTHER'S MAIDEN NAME Katherine Young, same as #2	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. SOCIAL SECURITY NO. 150-36-0573	
18. INFIRMANT Mrs. Katherine Sharp		19. ADDRESS 2008 Forest Dale Dr. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 27, 1967 , to March 22, 1967 , that (I) (we) last saw the deceased alive on Jan 30, 1967 , and that death occurred at 6:45 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Burton A. Johnson		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) BURTON A. JOHNSON, M.D.		22d. ADDRESS 11358 Cherry Hill Rd, Beltsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF March 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town or county) (State) Sanky Lake, Penna.
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR MAR 27 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

03276

03276

Handwritten notes and stamps, including "MAR 21 1961" and "MAR 21 1961".

03877

CERTIFICATE OF DEATH

03876

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Florida	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 48-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Nursing Home		d. STREET ADDRESS Bal Harbour	
3. NAME OF DECEASED (Type or print) Adele Treger		4. DATE OF DEATH Month MARCH Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1902
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Merchant	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Treger		14. MOTHER'S MAIDEN NAME Annie Gordon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 18 9173	
17. INFORMANT Brother 4819 Poik Avenue		Ely J. Treger - Alexandria, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 Arteriosclerotic heart disease DUE TO (a) _____ (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19 _____, to March 12, 1967 , that (I) (we) last saw the deceased alive on MARCH 8, 1967 , and that death occurred at 1:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Weslym Oler		22b. DATE SIGNED MARCH 12 '67	
22c. PHYSICIAN'S NAME (Type) Weslym Oler MD		22d. ADDRESS 4011 Randolph Rd., Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-67	
23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery		23d. LOCATION (City or Town) (County) (State) Oxon Hill, Maryland	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons Washington DC		25. REC'D BY REGISTRAR MAR 15 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03878

CERTIFICATE OF DEATH

03877

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 11 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Hills Nursing Home		d. STREET ADDRESS 2405 Arcola Ave.	
3. NAME OF DECEASED (Type or print) First Lillie Middle May Last Mancini		4. DATE OF DEATH March 24 1967 Month Day Year	
5. SEX F	6. COLOR OR RACE Can	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1896 9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Chevy Chase, Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Pugh		14. MOTHER'S MAIDEN NAME Elizabeth Clark Phillips Pugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-7880	
17. INFORMANT Mrs. Robert Mancini		Address 9610 Bristol Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1966 to 3/24 1967 that (I) (we) last saw the deceased alive on 3/24 1967 , and that death occurred at 1142 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. F. Thibadeau		22b. DATE SIGNED 3/24/67	
22c. PHYSICIAN'S NAME (Type) A. F. THIBADEAU		22d. ADDRESS 10111 Colesville Rd. Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-28-67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Prince George County, Md.
24. FUNERAL DIRECTOR Robert A. Pugh		25a. REC'D BY REGISTRAR MAR 30 1967	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03873

RECORD OF DEATH

03873

1900-1901

1900-1901

03879

CERTIFICATE OF DEATH

03878

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>4890 Battery Lane, 322</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Iola</u> Last <u>Mari</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-10</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington - D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Mr. John Veasy Mason</u>	
14. MOTHER'S MARRIED NAME <u>Sally Ann Senelton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-38-7083</u>		17. INFORMANT <u>Mr. Adolph Mari - above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>194X</u> <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO (b) <u>METASTATIC UNDIFFERENTIATED</u> DUE TO (c) <u>CARCINOMA OF THYROID</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 7</u> , 19 <u>49</u> , to <u>MAR. 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAR 29</u> , 19 <u>67</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>MAR. 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Paulina Lowe</u>		25a. RECD BY REGISTRAR <u>APR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03878

STATE OF TEXAS

03878

THIS IS TO CERTIFY THAT THE ABOVE NAMED PARTY HAS BEEN DULY EXAMINED AND FOUND TO BE A RESIDENT OF THE STATE OF TEXAS AND IS ELIGIBLE TO VOTE IN THE ELECTIONS TO BE HELD ON THE 11TH DAY OF NOVEMBER NEXT.

03880

CERTIFICATE OF DEATH

03879

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 9 hrs 1 min c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hospital		d. STREET ADDRESS 16301 Old Orchard Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Lyon Last Marletta		4. DATE OF DEATH Month March Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1967
9. AGE (In years last birthday) yrs. 15-1		IF UNDER 1 YEAR Months 9 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Montgomery Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph John Marletta		14. MOTHER'S MAIDEN NAME Beverly Ann Slocum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no None		16. SOCIAL SECURITY NO. none	
17. INFORMANT Joseph Marletta		Address 16301 Old Orchard Rd. S.S.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and Hyaline membrane Disease of newborn 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyaline membrane Disease 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH
21. I certify that (I) (this hospital) attended the deceased from 3/8 , 19 67 , to 3/8 , 19 67 that (I) (we) last saw the deceased alive on 3/8 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE H. H. Diamond		22b. DATE SIGNED 3/8/67	
22c. PHYSICIAN'S NAME (Type) H. H. DIAMOND		22d. ADDRESS 911-SILVER SPRING AVE S.S. MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR MAR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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03881

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04013

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>16-2</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash Sant Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville (LEWISDALE)</i> d. STREET ADDRESS <i>2104 Banning Place</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Evelyn G. Martin</i>		4. DATE OF DEATH Month <i>3</i> Day <i>20</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 29 - 1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	9. AGE (In years last birthday) yrs. <i>67</i>
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>August B. Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Julia Waldin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>GEORGE F. MARTIN SR</i>		Address <i>AS # 2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of Vomitus due to Toxic State</i> DUE TO (b) <i>Broncho-Pneumonia</i> DUE TO (c) <i>Diabetes Mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>In Toxic state - Vomited & aspirated food</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>12</i> p.m. <i>320</i> 1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Hyattsville - Prince George Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John B. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>3/20/66</i>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/> (Specify)	23b. DATE THEREOF <i>3/24/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL</i>	23d. LOCATION (City or Town) (County) (State) <i>SUITLAND MD.</i>
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS CO.</i>		25a. REC'D BY REGISTRAR <i>SILVER SPRING</i>	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1013

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03882

CERTIFICATE OF DEATH

03880

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Wash., D.C. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD.		c. LENGTH OF STAY IN lb 17 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 6008 Mass. Ave., N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Luddy First Middle Last		4. DATE OF DEATH March 6 19 67 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1878
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Idaho	
11. BIRTHPLACE (County & State, or foreign country) Idaho		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -- Henderson		14. MOTHER'S MAIDEN NAME Morton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Son John C. Martin		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min. 3 hrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 19 1967 , to March 6 19 1967 , that (I) (we) lost the deceased on March 4 1967 , and that death occurred at 12:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Ronald W. Barr		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) RONALD W. BARR, MD		22d. ADDRESS 1044 OLD GEORGETOWN RD BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-7-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Robert C. Humphrey		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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James

James J. Davis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03883

CERTIFICATE OF DEATH

03881

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 15 <u>10 days</u>		d. STREET ADDRESS <u>10613 Concord Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. William Fletchal Matthews</u>		4. DATE OF DEATH Month Day Year <u>March 11 19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-68</u>
9. AGE (In years last birthday) <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B & O Railroad Station Agent</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>709-078493</u>	
17. INFORMANT <u>Russell Matthews</u>		Address <u>8803 Riggs Road Adelphi, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Anemia, hypochromic severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>1-2 days</u> <u>3-4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <u>old age (98 yrs old) Enlarged liver & jaundice.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>6-9</u> , 19 <u>66</u> , to <u>3-11</u> , 19 <u>67</u> , that (1) we last saw the deceased alive on <u>3-10</u> , 19 <u>67</u> , and that death occurred at <u>6:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>3-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>		22d. ADDRESS <u>BURTONSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Baptist Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cedar Grove, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

03881

STATE OF TEXAS

03883

County of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03884

CERTIFICATE OF DEATH

03882

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY 83-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovettsville		d. STREET ADDRESS Route 2, Box 111	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence C. MCCALL		4. DATE OF DEATH Month Day Year March 29 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1914
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Ridgewood, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Post Coburn		14. MOTHER'S MAIDEN NAME Florence Woodward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 231 66 6680	
17. INFORMANT Lovettsville Charles E. McCall, Route 2, Box 111		Address Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Infraction of the Bowel DUE TO Anemia Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Secondary to Leukemia (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour :m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 17 , 19 67 , to Mar. 29 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 29 , 19 67 , and that death occurred at 1150 M. from causes and on the date stated above.			
22a. SIGNATURE R. J. Kinney MD		22b. DATE SIGNED Mar. 30, 1967	
22c. PHYSICIAN'S NAME (Type) R. J. Kinney MD		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) New York N.Y.	
24. FUNERAL DIRECTOR Muse & Reed, Inc. 101 Edwards Ferry Road, Leesburg, Virginia		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03888

CRIMINAL RECORD

03888

Virginia

Montgomery

Levittown

12 days

(Tues) (Tues)

Route 2, Box 111

Levittown

C. M. C.

Levittown

Box 111

Levittown

USA

Highwood, New Jersey

N/A

Levittown

Levittown

Levittown

Levittown, Route 2, Box 111

Levittown

Levittown

Levittown

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Levittown

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03883

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN lb 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Missouri b. COUNTY Bucklin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bucklin d. STREET ADDRESS RFD #2 Box 8 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul 4. DATE OF DEATH March 25 19 67		5. SEX Male 6. COLOR OR RACE Cauc 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 7, 1946 9. AGE (In years lost birthday) yrs. 21 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USA 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Barry R. McCarty 14. MOTHER'S MAIDEN NAME UNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 16. SOCIAL SECURITY NO. 494-48-9870 17. INFORMANT Navy records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Sereve DUE TO (b) Trauma From Auto Accident DUE TO (c) 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost control of car and crashed into another car 20c. TIME OF INJURY Month, Day, Year 10:00 m. Mar. 23 19 67 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXX Street 20f. (City or town) (County) (State) Alexander Va.		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) John G. Ball MD, Deputy		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 3/26/67 22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/28/67 23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove 23d. LOCATION (City or Town) (County) (State) Bucklin Missouri		24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W. Washington, D. C. 25a. RECD BY REGISTRAR 29 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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2. *Journal of the American Medical Association*, 1964; 191: 1000-1001.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03886

CERTIFICATE OF DEATH

03884

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Danville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 1217 Glen Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Augusta Last McClelland				4. DATE OF DEATH Month March Day 26 Year 19 67			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 August 1950	
9. AGE (In years last birthday) yrs. 16		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Philemon Augusta McClelland		14. MOTHER'S MAIDEN NAME Katherine Irving			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Jaundice of unknown etiology							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 March , 19 67 , to 26 March , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 26 March 19 67 , and that death occurred at 3:40 M. from causes and on the date stated above.							
22a. SIGNATURE Leroy Fass				22b. DATE SIGNED 27 March 1967		22c. PHYSICIAN'S NAME (Type) Leroy Fass, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				22e. REC'D BY REGISTRAR P.M.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/28/67		23c. NAME OF CEMETERY OR CREMATORY Oak Hill		23d. LOCATION (City or Town) (County) (State) Danville, Virginia	
24. FUNERAL DIRECTOR Washington D Shelleys				25a. REC'D BY REGISTRAR 1720 N Mound		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MONTGOMERY MARYLAND									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					c. LENGTH OF STAY IN 1b <u>151</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NRSG HOME 2101 FAIRLAND RD</u>					d. STREET ADDRESS <u>1212 FAIRLAND ROAD</u>				
3. NAME OF DECEASED (Type or print) <u>MINERVA</u>		First <u>MINERVA</u> Middle <u>-</u> Last <u>McCulloch</u>		4. DATE OF DEATH <u>MARCH 7 1967</u>		Month <u>MARCH</u> Day <u>7</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-1874</u>		9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>LEXINGTON KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK GRISWOLD CLUCK</u>					14. MOTHER'S MAIDEN NAME <u>CLARK</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-54-8408-T</u>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <u>Cerebro-vascular accident</u> (c) <u>Cardiac ischemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u> <u>2 1/2 yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>30</u> , to <u>March 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 7</u> , 19 <u>67</u> , and that death occurred at <u>140</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Katherine A. Chapman</u>					22b. DATE SIGNED <u>March 7, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>Katherine A. Chapman</u>					22d. ADDRESS <u>3924 Baltimore St, Kensington, Md. 20795</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/8/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg Maryland</u>			
24. FUNERAL DIRECTOR <u>Edith M. Waters</u>		ADDRESS <u>254 Carroll St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03888

CERTIFICATE OF DEATH

03886

1. PLACE OF DEATH a. COUNTY <u>montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d. STREET ADDRESS <u>4633 South 4th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Julia Jones</u> First Middle Last		4. DATE OF DEATH <u>March 2</u> Month Day Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1914</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Vandemere, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>O'Connor Lee Jones</u>		14. MOTHER'S MAIDEN NAME <u>Susan Frances Linton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>231 07 1019</u>	
17. INFORMANT <u>4th St. Arlington Va.</u>		18. INFORMANT <u>Capt. Fred E. McEntire, Jr., 4633 South</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5400</u> IMMEDIATE CAUSE (a) <u>Gastric ulcer with hemorrhage</u> Massive bilateral pulmonary atelectasis/ DUE TO (b) <u>Gastric ulcer with hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease with cerebral encephalomalacia</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 28</u> , 19 <u>67</u> , to <u>March 2</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 2</u> , 19 <u>67</u> , and that death occurred at <u>730A M.</u> from causes on the date stated above.			
22a. SIGNATURE <u>William R. Hix</u>		22b. DATE SIGNED <u>3 March 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. Hix</u>		22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Va.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Arlington Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>3901 North Fairfax Dr. Arlington, Va.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONTINUED OF DEATH

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FOR STATE
HEALTH DEPT.

03889

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03887

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>Wheaton</u>	
c. LENGTH OF STAY IN 1b <u>15 months</u>		d. STREET ADDRESS <u>11506 Bucknell Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11506 Bucknell Dr apt#</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MILDRED C. McFARLAND</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>W F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1905</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond B. Cobb</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Elden Mc Farland</u> Address <u>11506 Bucknell Drive Wheaton, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis due to</u> DUE TO <u>Adenocarcinoma of cecum with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>3/29/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street, City, town, or county) <u>Wheaton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>April 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Covington, Kentucky</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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U.S.A.

London Box

1971 2nd year
London, England

Letter to Sir and

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Investigative Report

Investigative Report, 1971, London, England

1971 2nd year

London, England

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03880

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03888

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hosp.</u>			d. STREET ADDRESS <u>8026 - 14th ave apt 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Rosemary Zeis McKenney</u> First Middle Last			4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-14</u>		9. AGE (In years lost birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash, D.C.</u>	
13. FATHER'S NAME <u>Edmund C. Zeis</u>			14. MOTHER'S MAIDEN NAME <u>Catherine O'Dwyer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Sameul McKenney Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u>years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 m.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>3/10/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
23d. LOCATION (City or Town) <u>Suitland Prince Geo Md</u>		23e. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23g. ADDRESS <u>131 11 S. B</u>		23h. CITY <u>Wash, D.C. 20003</u>		23i. DATE <u>MAR 13 1967</u>	

03888

03888

Cardiac Resection Disease
Coronary Artery Disease

John A. Jones

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained for use by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03891

CERTIFICATE OF DEATH

Reg. Dist. No. 03889

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 15-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10600 St. Paul Street		d. STREET ADDRESS 10600 St. Paul Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JANE Middle FOX Last McMAHON		4. DATE OF DEATH Month March Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 27, 1897
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Railroad		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Montgomery Fox		14. MOTHER'S MAIDEN NAME Fannie Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 1930	
17. INFORMANT Husband Joseph M. McMahon		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC DEBILITATION DUE TO (c) MALIGNANT BRAIN TUMOR		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 8 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1966 , to March 12 , 19 67 , that I last saw the deceased alive on March 11 , 19 67 , and that death occurred at 7:40 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11,000 Old Georgetown Road DATE SIGNED March 12, 67			
ACTUAL SIGNATURE Robert T. Thibadeau		M.D. 11,000 Old Georgetown Road March 12, 67	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Rockville, Maryland, 20852	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-15-67	22c. NAME OF CEMETERY OR CREMATORY Andrews Chapel Cemetery, Vienna, Virginia	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		24. REC'D BY REGISTRAR 16 1967	
24b. REGISTRAR'S SIGNATURE Charles J. J...			

CERTIFICATE OF DEATH

1933

MONDAY

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>		<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>RELATIONSHIP OF REPORTER TO DECEASED</p>		<p>RESIDENCE OF DECEASED</p>		<p>RESIDENCE OF REPORTER</p>		<p>DATE OF REPORT</p>		<p>SIGNATURE OF REPORTER</p>		<p>SIGNATURE OF PHYSICIAN</p>	
<p>DATE OF INTERVIEW</p>		<p>DATE OF EXAMINATION</p>		<p>DATE OF BURIAL</p>		<p>DATE OF CREMATION</p>		<p>DATE OF REINTERMENT</p>		<p>DATE OF REINTERMENT</p>	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN AND A REPORTER WHOSE NAMES ARE ON THE LIST OF QUALIFIED PERSONS MAINTAINED BY THE STATE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03892

CERTIFICATE OF DEATH

03890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>15.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4220 EVERETT ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>SHERIDAN</u> Last <u>MEESE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-18</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief-Economist-U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Meese</u>				14. MOTHER'S MAIDEN NAME <u>Anna Sayford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes U.S. Army</u>		16. SOCIAL SECURITY NO. <u>217-34-0683</u>		17. INFORMANT <u>Norman Meese - Son - Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>55</u> , to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/27/67</u> 19 <u>67</u> , and that death occurred at <u>3:30 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John E. Everett</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>				22d. ADDRESS <u>9400 Conn. Av. Kensington Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hine Co.</u>		ADDRESS <u>2801-14th St. Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03830

GENERAL C. BROWN

03830

SEAL-10-103

Produced Pursuant to Protective Order in Case No. 03-103

Page 10 of 10

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03893

CERTIFICATE OF DEATH

03891

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Greece b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Almiro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS Vrynena, Magnesis		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John (None) Melemes				4. DATE OF DEATH Month Day Year March 29 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 June 1935		9. AGE (In years last birthday) yrs. 31	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? Greece	
13. FATHER'S NAME Christos Melemes				14. MOTHER'S MAIDEN NAME Vasiliki Makri			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Ventricular Arrhythmias DUE TO (c) Calcific Aortic Stenosis							INTERVAL BETWEEN ONSET AND DEATH seconds 2 1/2 hours 11 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Open heart surgery precipitated death							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from 10 March , 1967, to 29 March , 1967, that (X) (we) last saw the deceased alive on 29 March , 1967, and that death occurred at 5:15 M. , from causes on and on the date stated above.							
22a. SIGNATURE <i>Lee Patrick Enright</i>				P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 31 March 1967	
22c. PHYSICIAN'S NAME (Type) Lee Patrick Enright, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-5-67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Almiro Greece	
24. FUNERAL DIRECTOR Proctor 389 R.I. - care W.W. - W.C.				25a. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03894

CERTIFICATE OF DEATH

03892

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 12 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 313 University Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice Eudora Mellinger		4. DATE OF DEATH Month Day Year 1967 March 1 19 67	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-88
9. AGE (in years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Charles Snyder		14. MOTHER'S MAIDEN NAME Ella F. Glotfeldy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5702 DUE TO Mesenteric Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24-30-67 , 19 67 , to 12 MAR , 19 67 that (I) (we) lost the deceased alive on 2-28 19 67 and that death occurred at 1 M, from causes and on the date stated above.			
22a. SIGNATURE Morell C. Quinnas		22b. DATE SIGNED 3/1/67	
22c. PHYSICIAN'S NAME (Type) MORELL C. QUINNAS		22d. ADDRESS Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/67	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Md.	
24. FUNERAL DIRECTOR Charles Snyder		25a. REC'D BY REGISTRAR Charles Snyder	
25b. REGISTRAR'S SIGNATURE Charles Snyder		DATE 3/1/67	

MAR 6 1967

03230

RECEIVED OF DEATH

03230

MAR 8 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03895

CERTIFICATE OF DEATH

03895

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 2801 East-West Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur L. Miller		4. DATE OF DEATH Month Day Year March 16 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1892 9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Physician	
11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME R. J. Miller		14. MOTHER'S MAIDEN NAME - - - Louis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Margaret J. KXXX Miller,		Address See Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4201 Congestive heart failure DUE TO (b) Ischemic heart disease DUE TO (c) Coronary Artery Disease (Arteriosclerosis)		INTERVAL BETWEEN ONSET AND DEATH 8 mo 8 years 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis obliterans; Arteriosclerotic Cerebrovascular & Renal ds		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/22, 1959 to 3-16, 1967 that (I) (we) last saw the deceased alive on Feb 23, 1967 and that death occurred at 8:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Andrew G Prandoni		22b. DATE SIGNED 3-16-67	
22c. PHYSICIAN'S NAME (Type) Andrew G Prandoni		22d. ADDRESS 2520 L St NW Washington DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-20-1967	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Md.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR Mar 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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OFFICE OF THE SECRETARY

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03896

CERTIFICATE OF DEATH

03894

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN lb 1 month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8201 16th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ethel (no middle name) Miller				4. DATE OF DEATH Month March Day 13 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/1/1903	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady & housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Nathan Fisman				14. MOTHER'S MAIDEN NAME Bessie Levinsen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Lewis Miller-807 Caddington Ave., Address Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastatic disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) breast carcinoma of breast DUE TO (c) 4 yrs.						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 years ago to Mar 13, 1967 , that (I) (we) last saw the deceased alive on Mar 13, 1967 , and that death occurred at 7:30 P. M, from causes and on the date stated above.							
22a. SIGNATURE Sydney Leventhal M.D.				22b. DATE SIGNED Mar 13, 1967		22c. PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.	
22d. ADDRESS 9210 Colesville Rd., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 3/13/67		23c. NAME OF CEMETERY OR CREMATORY --		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company Washington, D.C.				25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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40250

2250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03897

CERTIFICATE OF DEATH

03895

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN IB		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3924 Decatur Avenue</i>				d. STREET ADDRESS <i>3924 Decatur Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>WILLIAM</i> Middle <i>DAVID</i> Last <i>MILLER</i>		4. DATE OF DEATH Month <i>March</i> Day <i>17</i> Year <i>1967</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 29, 1912</i>	9. AGE (In years last birthday) <i>54</i> yrs.	IF UNDER 1 YEAR Months <i>54</i> Days <i>17</i> Hours <i>19</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bricklayer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William David Miller Sr.</i>				14. MOTHER'S M maiden NAME <i>Margaret Haller</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214 03 8609</i>		17. INFORMANT <i>Mrs. Jeanne P. Miller (same as #2)</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 coronary + thrombosis</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral arteriosclerosis, generalized arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>16 minutes</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/18/67</i> , 19 <i>67</i> , to <i>3/17</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/17/67</i> 19 <i>67</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Patrick C. Jameson</i>				22b. DATE SIGNED <i>3/18/67</i>		22c. PHYSICIAN'S NAME (Type) <i>PATRICK JAMESON</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 21, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grange Washington</i>		23d. LOCATION (City, town or county) (State) <i>Adelphi, Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St NW. D.C.</i>				25a. REC'D BY REGISTRAR <i>MAR 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03898

CERTIFICATE OF DEATH

03896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>	
c. LENGTH OF STAY IN 1b <u>3 wks. 20 min.</u>		d. STREET ADDRESS <u>11503 NAIRN RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY MOORE</u>		4. DATE OF DEATH <u>3/16/67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/03</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Real Estate</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IND. USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William P. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>290-22-5999</u>	
17. INFORMANT <u>Mrs. Vincent Oliverio</u>		Address <u>11503 Nairn Road Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>Diabetes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16, 1967</u> to <u>March 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 16, 1967</u> , and that death occurred at <u>1:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>March 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>1641 Columbia Rd Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>March 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cincinnati, Ohio</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>18434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>MAR 22 1967</u>	

03228

CENTRAL DE DEATH

03228

Handwritten: 03228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03899

CERTIFICATE OF DEATH

03897

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KEESINGTON		c. LENGTH OF STAY IN 1b --		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KEESINGTON Washington, D.C. 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL HALL SANITARIUM				d. STREET ADDRESS 5118 Westridge Rd., N. W.	
3. NAME OF DECEASED (Type or print) First Ethel		Middle P		Last Mott	
4. DATE OF DEATH Month MARCH		Day 8		Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1886	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME RICHARD R. PITT		14. MOTHER'S MAIDEN NAME ALINE DIXON Wickhouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 231-10-8878		17. INFORMANT RICHARD A. MOTT-5118 WESTRIDGE RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Atrial fibrillation with heart failure DUE TO (b) CORONARY ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERAL SOLID				INTERVAL BETWEEN ONSET AND DEATH 36 hours 1 year 54 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	
20f. (City or town) --		20g. (County) --		20h. (State) --	
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1966 , to March 8, 1967 , that (I) (we) last saw the deceased alive on March 8, 1967 , and that death occurred at 7:30 PM , from the causes and on the date stated above.					
22a. SIGNATURE Frank S. Bacon				22b. DATE SIGNED MARCH 8, 1967	
22c. PHYSICIAN'S NAME (Type) Frank S. Bacon				22d. ADDRESS 2141-K-Street N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3-10-1967		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
23d. LOCATION (City, town or county) Norfolk, Va.		23e. REC'D BY REGISTRAR Charles Judge		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Joseph Howler Sons		24a. ADDRESS Wash., D.C.		24b. DATE MAR 13 1967	

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MAR 18 1985

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03898

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>35 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Owen Fisher Mullen</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		9. AGE (In years lost birthday) <u>90</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
13. FATHER'S NAME <u>Owen Edward Mullen</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Caroline Fisher</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Walter W. Mullen</u> Address <u>2712 Emmett Road Sil Spg., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 9040 IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Fracture - Hip</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>59 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at home causing fracture of Hip</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>1</u> 8 1967 p.m.		20d. INJURY OCCURRED <u>2</u> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington D.C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> EXAMINER'S NAME (Type)		22. DATE SIGNED <u>3/6/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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Kensington Gardens Nurseries 1012 Manor Ave SE
 3-24-50
 Owen Fisher Miller
 M- W X
 May 12 1950

Owen Fisher Miller
 2711 Sunset Road
 Los Angeles 24, California

Biological Research
 Colorado Technical Institute
 2100

Free of house company factors of 100

John 1950
 3/10/50

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03899

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8719-Irvington St.</u>	
3. NAME OF DECEASED (Type or print) <u>Creston B. Mullins</u>		4. DATE OF DEATH <u>March 26 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/107</u>
9. AGE (In years last birthday) <u>59</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Information Cont.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Information Cont.</u>	
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Mullins</u>		14. MOTHER'S MAIDEN NAME <u>Aurora Black</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes. Navy war</u>		16. SOCIAL SECURITY NO. <u>578-09-8637</u>	
17. INFORMANT <u>Josephine Mullins</u>		Address <u>15 Ave. Asbury</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BURNS - 2nd + 3rd degree - of 90% of body</u> DUE TO (b) <u>16 hr.</u> DUE TO (c) <u>9160</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell asleep in chair while smoking cigarette</u>			
20c. TIME OF INJURY Month, Day, Year <u>1230 3/26 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>3/26/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-30-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Alexandria Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Alexandria, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

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03902

CERTIFICATE OF DEATH

03900

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seneca Md</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seneca, Md</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>River Road</u>				d. STREET ADDRESS <u>River Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>ROBERT MURRAY</u> Middle Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>67</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 2, 1906</u>		
				9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>								
13. FATHER'S NAME <u>Robert Murray</u>				14. MOTHER'S MAIDEN NAME <u>Mary Nelson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth Murray item #2</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydropneumonia</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Adenocarcinoma of the sigmoid colon</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2 Nov</u> , 19 <u>66</u> , to <u>16 March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 March</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>John S. Fawcett</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>19 March 67</u>		
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>P.O. BOYDS Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Seneca Coun. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Seneca Montg Md.</u>		
24. FUNERAL DIRECTOR <u>Robert L. Snowden Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03903

CERTIFICATE OF DEATH

03901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN lb <i>5 mos 22 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington, D. C.</i> b. COUNTY <i>47-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>		d. STREET ADDRESS <i>5519 Nevada Avenue, N. W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Georgia</i> Middle <i>9.</i> Last <i>Myers</i>		4. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>19 67</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 2, 1876</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Urichsville, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Harper</i>		14. MOTHER'S MAIDEN NAME <i>Mary Barr</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-54-6419</i>	
17. INFORMANT <i>Dorothy G. Mergner</i>		Address <i>5519 Nevada Ave., N. W. Washington, D. C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>3-5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>old CVA, decubitus ulcers & cellulitis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-9</i> , 19 <i>66</i> , to <i>3-28</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10-9 3-22 1967</i> , and that death occurred at <i>2:55 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>R. H. Sandstrom M.D.</i>		22b. DATE SIGNED <i>3-29-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom M.D.</i>		22d. ADDRESS <i>7701 Carroll Ave Takoma Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar 30, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>John B. Thomas</i> <i>4434 Georgia Avenue</i> <i>Silver Spring, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>MAR 31 1967</i>	

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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3/22/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	23d. LOCATION (City or Town) (County) (State) <i>Petoskey, Michigan</i>
24. FUNERAL DIRECTOR <i>John E. Thomas Warner & Pumphrey, Inc.,</i>	ADDRESS <i>8434 Ga. Ave., S.E., Md.</i>	25a. REC'D BY REGISTRAR <i>MAR 22 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the results of the study. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

12 1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03905

CERTIFICATE OF DEATH

03903

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3801 Williams Lane		d. STREET ADDRESS 3801 Williams Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RICHARD TEMPLEMAN NAYLOR		4. DATE OF DEATH Month March Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1878
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Banker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Naylor		14. MOTHER'S MAIDEN NAME Charlotte Templeman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Sister		Address Same as Item 2. Margaret N. Lauderdale	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cardiovascular Disease DUE TO (c) Years.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to date , 19 67 , that (I) (we) last saw the deceased alive on 14 March 1967 , and that death occurred at 3:30 AM, from causes and on the date stated above.			
22a. SIGNATURE John G. Ball		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) JOHN G. BALL		22d. ADDRESS 7936 Old Georgetown Rd. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-67	
23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03906

CERTIFICATE OF DEATH

03904

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 419 Reading Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Mary A. Nellinger		4. DATE OF DEATH Month Day Year March 27 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1882
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 15.1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Fulmer		14. MOTHER'S MAIDEN NAME ? Hargate	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. 213-56-0542	
17. INFORMANT Medical Records		Address Olney, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE MASSIVE DUE TO (b) CEREBRAL ARTERIOSECTOSIS DUE TO (c) HYPER TENSIVE CARDIOVASCULAR DIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH 4 YRS 5-10 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) ASPIRATION PNEUMONITIS - TERMINAL			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 3/27, 1967 , that (2) (we) last saw the deceased alive on 3/27 1967 , and that death occurred at 12:45 M , from causes and on the date stated above.			
22a. SIGNATURE Ronald R. Lewis		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) D. R. Lewis, M.D.		22d. ADDRESS Medical Center, Sandy Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-30-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

CASE REVIEWED & DISCLOSED TO MONT. CO. MEDICAL EXAMINER

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>16 days</u>		d. STREET ADDRESS <u>903 Baltimore Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frances Gaither Nichols</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/1869</u>
9. AGE (In years last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene C. Gaither</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-52-3076T</u>	
17. INFORMANT <u>Y. Eugene Nichols</u>		Address <u>1646 St. Anthony</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism -</u> DUE TO (b) <u>Fracture of Right Hip -</u> DUE TO (c) <u>Cardiovascular Disease -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>16 days.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at Nursing Home causing Fracture Rt Hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:30</u> a.m. <u>2/18</u> 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) - (County) (State) <u>Rockville - Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>3/6/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF <u>3-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Gaithersburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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03002

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "John", "John", "John" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03908		CERTIFICATE OF DEATH				03906			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 151				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>5519 McKinley St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary SLACK</u> <u>Nicholson</u>					4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>12-14/86</u>		9. AGE (In years last birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Paul Slack</u>					14. MOTHER'S MAIDEN NAME <u>Juliet Buckley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>			16. SOCIAL SECURITY NO. <u>577-03-7636</u>		17. INFORMANT <u>Mrs. Wm. Slack Nicholson</u> Address <u>same as above</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Thromboses</u> DUE TO <u>Congestive Heart Failure</u> (b) <u>Atherosclerosis & coronary</u> DUE TO <u>Heart Disease & Cong. Heart Failure</u> (c) <u>Heart Disease & Cong. Heart Failure</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>67</u> , to <u>3/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/16/1967</u> , and that death occurred at <u>5:15</u> P.M. from causes and on the date stated above.									
22a. SIGNATURE <u>W. T. Joyce</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>3-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. T. Joyce</u>					22d. ADDRESS <u>4977 Battery Lane, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR <u>DATE MAR 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

03300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03909

CERTIFICATE OF DEATH

03907

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf 18.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 1012 Stoddert Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eileen Mary O'ROURKE				4. DATE OF DEATH Month Day Year March 28 19 67			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 May 1916		9. AGE (In years lost birthday) yrs. 50	IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Technician		10b. KIND OF BUSINESS OR INDUSTRY Printing Bur. Engraving		11. BIRTHPLACE (County & State, or foreign country) Toledo, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eiler Nelson				14. MOTHER'S MAIDEN NAME Mary Gizenlenk			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Waldorf Address Md. James I. O'Rourke, 1012 Stoddert Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast with widespread metastases DUE TO (b) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 170X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Mar. 17 , 19 67 , to Mar. 28 , 19 67 that (we) (we) lost saw the deceased alive on Mar. 28 , 19 67 , and that death occurred at 1:45 PM , from causes on and on the date stated above.							
22a. SIGNATURE Francis D. Keenan, Jr., M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 30 Mar. 1967	
22c. PHYSICIAN'S NAME (Type) Francis D. Keenan, Jr., M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial-transit 3-21-67		23c. NAME OF CEMETERY OR CREMATORY Golden Gate National Cemetery, San Bruno, Calif.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland				25a. REC'D BY REGISTRAR ARK 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03204

03204

Maryland

Montgomery

Waldorf

11 days

Robinson (Trent)

1012 Woodmont Ave.

Naval Hospital

U.S. Navy

Mary

Kilgus

Cano

Female

8 May 1918

Princeton

Toledo, Ohio

Academic Institution for Training

Army Officer

River Station

James I. O'Connell, 1012 Woodmont Ave.

W. H. II

Yes

Cardinal's House with adjacent residence

Mar. 29

Mar. 17

Mar. 20

Mar. 30

Wanda A. Morgan, Jr., M.D., Naval Hospital, Bethesda, Md.

Wanda A. Morgan, Jr., M.D., Naval Hospital, Bethesda, Md.

Wanda A. Morgan, Jr., M.D., Naval Hospital, Bethesda, Md.

Wanda A. Morgan, Jr., M.D., Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03910

CERTIFICATE OF DEATH

03908

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 84 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, NIH, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Judith Marie Osenlund		4. DATE OF DEATH Month March Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 October 1946
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Karl Osenlund		14. MOTHER'S MAIDEN NAME Marie O'Brien	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Records, The Clinical Center, National Institutes of Health, Bethesda, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) Staphylococcal Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (bilateral) DUE TO (c) Acute Lymphocytic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 48 Hours 4 Days 17 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Meningeal Leukemia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 27 December, 19 66 , to 21 March, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 March, 19 67 , and that death occurred at 8:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Jerry L. Spivak, MD.		22b. DATE SIGNED 21 March 1967	
22c. PHYSICIAN'S NAME (Type) Jerry L. Spivak, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 3-220-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

03908

03910

12-11-54

12-11-54

84 days

12-11-54

The National Center, Hill, Washington, D.C.

12-11-54

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The National Center, Hill, Washington, D.C.

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03911

CERTIFICATE OF DEATH

03909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH. a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 hour 32 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4202 Wicomico Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Inf Girl</u> First Middle Last <u>OVERMAN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David L. Overman</u>		14. MOTHER'S MAIDEN NAME <u>Carol Colvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Address <u>David L. Overman Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7625</u> IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>Immaturity (20 wks)</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>92 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2 PM, 1967</u> , to <u>2 PM, 1967</u> , that (I) (we) last saw the deceased alive on <u>2 PM, 1967</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. Hughes, M.D.</u>		22b. DATE SIGNED <u>3 Mar '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles R. Hughes MD</u>		22d. ADDRESS <u>911 Silver Spring Ave. S.S. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>MAR 7 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03203

CLINICAL OF DEATH

03203

Charles R. Hughes MD
PH 2104 2nd Ave 22 W

MAY 1 1951

CERTIFICATE OF DEATH

Reg. Dist. No.

03910

03912

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7609 Marbury Rd.				d. STREET ADDRESS 7609 Marbury Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARRIE Middle M. Last OXRIEDER				4. DATE OF DEATH Month March Day 3 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1876	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Judson W. Fuller				14. MOTHER'S MAIDEN NAME Eleanor J. Comstock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 287-44-0241			
17. INFORMANT Mrs. Mona A. Klepinger				Address Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. arteriosclerosis, gen.; cong. failure DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 25 July , 1966, to 3 March , 1967, that I last saw the deceased alive on 2 March , 1967, and that death occurred at 6:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7801 Norfolk Avenue DATE SIGNED ACTUAL SIGNATURE John M. Wyman M.D. PHYSICIAN'S NAME (Type) JOHN M. WYMAN, M.D. Bethesda, Maryland 20014							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/1967		22c. NAME OF CEMETERY OR CREMATORY Maple Grove		22d. LOCATION (City, town, or county) (State) Granville, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. RECEIVED BY REGISTRAR MAR 10 1967 DATE	
24b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

63910

CERTIFICATE OF DEATH

03912

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
1941		New York		Natural	
TIME OF DEATH		AGE		SEX	
10:00 AM		65		Male	
CAUSE OF DEATH		DISEASE		SPECIAL INQUIRY	
Heart Disease		Myocardial Infarction		None	
DATE OF BIRTH		PLACE OF BIRTH		MANNER OF BIRTH	
1876		New York		Natural	
TIME OF BIRTH		AGE		SEX	
10:00 AM		65		Male	
CAUSE OF BIRTH		DISEASE		SPECIAL INQUIRY	
Heart Disease		Myocardial Infarction		None	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
1941		New York		Natural	
TIME OF DEATH		AGE		SEX	
10:00 AM		65		Male	
CAUSE OF DEATH		DISEASE		SPECIAL INQUIRY	
Heart Disease		Myocardial Infarction		None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03912

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md.		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 616 Nelson St.		d. STREET ADDRESS 616 Nelson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Esperanza Eschoyez de Paolini		4. DATE OF DEATH Month March		Day 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 23 1897		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Argentina	
12. CITIZEN OF WHAT COUNTRY? Argentina		13. FATHER'S NAME Carlos Eschoyez		14. MOTHER'S MAIDEN NAME Neurenhousin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miguel Cascardo	
Address Rockville, Md.		616 Nelson St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency acute -</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease -</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
22. ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 3/19/67			
EXAMINER'S NAME (Type) John G. Ball		7936 Old Georgetown Road Bethesda, Maryland		22. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Montgomery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/20/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION (City, town or county) Prince George Co. Md.					
24. FUNERAL DIRECTOR Tyson Wheeler		1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

1950

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General Investigator -
Cardiovascular Disease -
1952

1951

John A. Ball

MAR 2 1951

19

03915

CERTIFICATE OF DEATH

03913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Potomac</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Taylor</u> Last <u>Papson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20-1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. GOVERNMENT ACCOUNTANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Howard City, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Papson</u>		14. MOTHER'S MAIDEN NAME <u>Edith Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes U.S. N. W. WAR</u>		16. SOCIAL SECURITY NO. <u>579-44-6280</u>	
17. INFORMANT <u>Ralph P. Aten-2853 Ontario Rd. N.W.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4500 IMMEDIATE CAUSE (a) <u>Pneumonia</u></u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1966</u> to <u>Mar. 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>May 25, 1967</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>The S. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03213

CERTIFICATE OF DEATH

03213

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03916

CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>700 60th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen L.</u> Middle <u>Parker</u> Last <u></u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1887</u>
9. AGE (In years lost birthday) yrs. <u>80</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired, so state) <u>Teacher (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christopher McKinney</u>		14. MOTHER'S MAIDEN NAME <u>Leonora Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>217-52-3381</u>	
17. INFORMANT <u>Donald Parker, Son</u>		Address <u>700 60th Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>central arteriosclerosis</u> (c) <u>general arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> 19 <u>67</u> to <u>March 28</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 27</u> 19 <u>67</u> , and that death occurred at <u>3:55 a</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry G. Hadley</u>		22b. DATE SIGNED <u>Mar 28 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry G. Hadley</u>		22d. ADDRESS <u>7601 Nichols ave SW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>highland Park, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1860

DEPARTMENT OF HEALTH

1860

Highland Park, Maryland

Harmony New York
1810 St. N.Y.
Washington, D.C.

W. J. L. 1860

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03917

Item #4 Film #G387 3/27/67 pc

CERTIFICATE OF DEATH

03915

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 70 Suburban Hospital		d. STREET ADDRESS 625 W. Lynfield Drive.	
3. NAME OF DECEASED (Type or print) Rosa L. Parker		4. DATE OF DEATH Month March Day 19 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8/20/1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John T. George		14. MOTHER'S MAIDEN NAME Lucinda Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 578-50-0419	
17. INFORMANT Margaret L. Frazier - daughter		Address same item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic lymphocytic leukemia DUE TO (c) arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 2-3 d 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerotic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 9, 1967 to May 19, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at 11:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter		22d. ADDRESS 50 W. Edmonston Drive, Rock. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS 1331 Rockville Pike Rockville, Maryland	
25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03912

STATE OF DEATH

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MONTGOMERY STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03918

CERTIFICATE OF DEATH

03916

1. PLACE OF DEATH a. COUNTY: <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: <u>MD</u> b. COUNTY: <u>MONT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE 151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>OLD COLUMBIA PIKE</u>		d. STREET ADDRESS <u>OLD COLUMBIA PIKE</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE ELIZABETH PARLEY</u>		4. DATE OF DEATH <u>MARCH 26 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25 1980</u>
9. AGE (In years last birthday) yrs. <u>86</u>		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HOWARD Co - MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK WILSON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE A. JAMIESON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-56-5782</u>	
17. INFORMANT <u>MISS CLARA COFF - Spouse</u>		Address <u>1531</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage - large intestine</u> 1531 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma splenic flexure</u> DUE TO (c) <u>Hemorrhagic shock & anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>malnutrition - secondary to above</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory; street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 30, 1966</u> to <u>MCH 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 26 1967</u> , and that death occurred at <u>3:15 P.M.</u> from causes on and the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>3-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>		22d. ADDRESS <u>BURTONSVILLE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>MAY 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Burtonsville Mont Co Md.</u>	
24. FUNERAL DIRECTOR <u>Robert Roudsamy</u>		ADDRESS <u>1531</u>	
25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03218

INTERNATIONAL OF LEAF

03218

1. NAME OF THE PARTY OR PARTIES CONCERNED		2. ADDRESS	
3. DATE OF BIRTH		4. DATE OF DEATH	
5. PLACE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. EDUCATION	
9. RELIGION		10. MARITAL STATUS	
11. DATE OF ENTRY INTO THE COUNTRY		12. DATE OF DEPARTURE FROM THE COUNTRY	
13. DATE OF ARRIVAL IN THE COUNTRY		14. DATE OF DEPARTURE FROM THE COUNTRY	
15. DATE OF DEATH		16. DATE OF BURIAL	
17. DATE OF INTERVIEW		18. DATE OF INTERVIEW	
19. DATE OF INTERVIEW		20. DATE OF INTERVIEW	
21. DATE OF INTERVIEW		22. DATE OF INTERVIEW	
23. DATE OF INTERVIEW		24. DATE OF INTERVIEW	
25. DATE OF INTERVIEW		26. DATE OF INTERVIEW	
27. DATE OF INTERVIEW		28. DATE OF INTERVIEW	
29. DATE OF INTERVIEW		30. DATE OF INTERVIEW	
31. DATE OF INTERVIEW		32. DATE OF INTERVIEW	
33. DATE OF INTERVIEW		34. DATE OF INTERVIEW	
35. DATE OF INTERVIEW		36. DATE OF INTERVIEW	
37. DATE OF INTERVIEW		38. DATE OF INTERVIEW	
39. DATE OF INTERVIEW		40. DATE OF INTERVIEW	
41. DATE OF INTERVIEW		42. DATE OF INTERVIEW	
43. DATE OF INTERVIEW		44. DATE OF INTERVIEW	
45. DATE OF INTERVIEW		46. DATE OF INTERVIEW	
47. DATE OF INTERVIEW		48. DATE OF INTERVIEW	
49. DATE OF INTERVIEW		50. DATE OF INTERVIEW	
51. DATE OF INTERVIEW		52. DATE OF INTERVIEW	
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93. DATE OF INTERVIEW		94. DATE OF INTERVIEW	
95. DATE OF INTERVIEW		96. DATE OF INTERVIEW	
97. DATE OF INTERVIEW		98. DATE OF INTERVIEW	
99. DATE OF INTERVIEW		100. DATE OF INTERVIEW	

UNITED STATES DEPARTMENT OF AGRICULTURE
OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE
WASHINGTON, D. C. 20250
1998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03919

CERTIFICATE OF DEATH

03917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		d. STREET ADDRESS <u>1319 Merrimac Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Pasis</u> Last <u>Pasis</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22 - 01</u>
9. AGE (In years lost birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAXI</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham L. Pasis</u>		14. MOTHER'S MAIDEN NAME <u>Anna Krupsa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-8518</u>	
17. INFORMANT <u>Wife - Mrs. Fannie Pasis</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, Emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/12</u> , 19 <u>67</u> , to <u>3/3</u> , 19 <u>67</u> , that (I) (we) least saw the deceased alive on <u>2/12</u> , 19 <u>67</u> , and that death occurred at <u>7:50</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Maurice Franks M.D.</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Maurice Franks M.D.</u>		22d. ADDRESS <u>1330 N.H. Ave. NW, 20036</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD</u>
24. FUNERAL DIRECTOR <u>Holberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4217-9th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 7 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03912

UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03920

CERTIFICATE OF DEATH

03918

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2601 Madison Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Florance R. Percock</u>				4. DATE OF DEATH <u>3</u> <u>11</u> <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/26/1922</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>John Myer</u>				14. MOTHER'S MAIDEN NAME <u>Ester (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-07-9860</u>		17. INFORMANT Address <u>2601 Madison Avenue Baltimore</u> <u>Mrs. Sophie R. Berman</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442 X</u> <u>Conjunctive Heart failure Pulmonary Edema Ate</u> DUE TO (b) <u>Cardiovascular Disease, Renal Shutdown</u> DUE TO (c) <u>Chronic Renal Disease, Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Chronic</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, GI Bleeding</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sub</u>			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Mar 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 11</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R. C. Bufalino, M.D.</u>				22b. DATE SIGNED <u>Mar 11, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino M.D.</u>				22d. ADDRESS <u>1429 University Blvd W. Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Inter-burial</u>		23b. DATE THEREOF <u>March 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ba'ni Jacob Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Charleston, West Virginia</u>	
24. FUNERAL DIRECTOR <u>Thomas John Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>Mar 16 1967</u>			

03218

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 90 Minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Massachusetts b. COUNTY Mattapan c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58-3 d. STREET ADDRESS 25 Old Morton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Richard Middle Wayne Last Pogue			4. DATE OF DEATH Month March Day 21 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 December 1912		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Medical Supplies		11. BIRTHPLACE (State or foreign country) Indiana			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Roscoe O. Pogue					14. MOTHER'S MAIDEN NAME Eva B. Thrope				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. (If yes give war or dates of service) 1944-1946		17. INFORMANT Address 493-36-0665				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Cardio Vascular Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. years.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John G. Ball					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) John G. Ball, MD.					22. DATE SIGNED 3/21/67 Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/24/67		23c. NAME OF CEMETERY OR CREMATORY Hampton National Cem.			23d. LOCATION (City, town or county) (State) Hampton, Virginia	
24. FUNERAL DIRECTOR Samuel S. Sauer					ADDRESS 1102 W. Broad St.		25a. REC'D BY REGISTRAR DATE MAR 27 1967		
					25b. REGISTRAR'S SIGNATURE Charles Judge				

03010

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Control Vascular Disease
Control Inflammatory Acute

X X

X

X 3/24/1

John D. Box

3/25/67 Hampton National Home, Hampton, Virginia
Wille Church, P. O. Box 1102, W. B. B. B.
MAR 27 1967
Wille Church, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

CLEARED BY MEDICAL EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03922			CERTIFICATE OF DEATH		
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>Hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>15-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>			d. STREET ADDRESS <u>1 MANCHESTER PLACE</u> <u>#302</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILBUR</u> Middle <u>David</u> Last <u>PRICE</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>19 67</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-21</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wayne County, N. C.</u>	
13. FATHER'S NAME <u>David W. Price</u>			14. MOTHER'S MAIDEN NAME <u>Cynthia Godwin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mrs. Violet Price</u> <u>19608 Fenbrook Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Intraventricular hemorrhage</u> DUE TO (b) <u>Essential hypertension</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fatty cirrhosis of liver</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>63</u> , to <u>3/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>67</u> , and that death occurred at <u>9:30 P.M.</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/2/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>			22d. ADDRESS <u>4115 Colie Drive Wheaton Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>March 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Greensboro, North Carolina</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>18434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03258

CENTRAL CT. DEATH

03258

Handwritten notes and stamps, including a circular seal on the left side of the page.

RECEIVED

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03913

CERTIFICATE OF DEATH

03911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8003-Rentbury Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian Newell</u> First Middle <u>FUDERER</u>		4. DATE OF DEATH <u>March 10</u> Month Day Year 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Supervisor Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carroll Harder Newell</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Wade Newton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Mrs. Wm. H. C. Lott</u>		Address <u>1320 1/2 E. ...</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X METASTATIC BREAST CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 1</u> , 19 <u>67</u> , to <u>MAR 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAR. 10</u> , 19 <u>67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Daddario</u>		22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u>		22d. ADDRESS <u>5413 CEDAR LANE, BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. Washington, D.C.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card ~~body~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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OFFICE OF STATE

FOOTNOTES

SECTION 101

SECTION 101

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03923

CERTIFICATE OF DEATH

03921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANDOVER</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER M. QUINN</u>		4. DATE OF DEATH <u>MARCH 12 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/13</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <u>Ont. CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>David Robert Quigge</u>		14. MOTHER'S MAIDEN NAME <u>Esther Sandford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vincent J Quinn</u>		Address <u>Landover, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>330X</u> IMMEDIATE CAUSE (a) <u>Intracerebral and subarachnoid hemorrhage</u> DUE TO (b) <u>due to ruptured Berry aneurysm</u> DUE TO (c) <u>due to ruptured Berry aneurysm</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>67</u> , to <u>3/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>67</u> , and that death occurred at <u>4:35 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Macon</u> M.D.		22b. DATE SIGNED <u>3/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Macon, M.D.</u>		22d. ADDRESS <u>809 Viers Mill Road, Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

09331

REQUIREMENT OF DEATH

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